GRAND PEAKS
MEDICAL • PHARMACY
DENTAL • BEHAVIORAL HEALTH

NEW PATIENT REGISTRATION

*Today's Date:*_____

PATIENT INFORMATION

Last Name | *First Name* | *Middle Initial* | *Preferred Name* | *Previous Name(s)*

Mailing Address *(Address/P.O. Box, City, State, and Zip code)*

Home Ph# | *Cell Ph#* | *Work Ph#*

Date of Birth | *Social Sec #* | *Gender at Birth* ☐ Male ☐ Female

Gender Identity ☐ Male ☐ Female ☐ Choose not to disclose ☐ Transgender Male/ Female to Male ☐ Transgender Female/ Male to Female ☐ Other

Sexual Orientation ☐ Choose not to disclose ☐ Straight ☐ Bisexual ☐ Lesbian or Gay ☐ Something else ☐ Don't know

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Sep. ☐ Widowed ☐ Partner

Employed? ☐ Yes ☐ No **If Yes:* ☐ PT ☐ FT *Self Employed?* ☐ Yes ☐ No *Student?* ☐ Yes ☐ No *If Yes:* ☐ PT ☐ FT

Employer | *Ph#*

Emergency Contact *(Name of local relative or friend not living with the pt)* | *Relationship to pt* | *Ph#*

Additional Contacts *(Spouse, Parent, etc. You may list more than one.)* | *Relationship to pt* | *Ph#*

Email Address (Preferably not a work email)

Race ☐ White ☐ Asian ☐ Black/African American ☐ Pacific Islander ☐ American Indian ☐ Alaskan Native

Ethnicity ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Primary Language Spoken ☐ English ☐ Spanish ☐ Other

Interpreter services needed ☐ Yes ☐ No

Are you a Veteran ☐ Yes ☐ No

Do you live in public Housing? ☐ Yes ☐ No

Are you Homeless ☐ Yes ☐ No **If Yes, mark one:* ☐ Doubling Up ☐ Street ☐ Homeless Shelter ☐ Transitional ☐ Other

Are you a Migrant worker? ☐ Yes ☐ No *Are you a Seasonal Worker*? ☐ Yes ☐ No

Preferred Communication ☐ Phone ☐ Text ☐ E-Mail ☐ Patient portal ☐ Mail

How did you hear about us (Friend, Advertisement, Facebook, Radio, etc.)

Preferred Pharmacy (Name, Location, Ph # if known)

Full names, DOB and relationship of other household members seen at Grand Peaks facilities *(Jane Doe, 1/1/2010, child):*

BILLING / INSURANCE INFORMATION

Guarantor (Person financially responsible for the bill) ☐ Patient is the guarantor/financially responsible, skip to insurance

Full Name (First, Middle Initial, Last) | *Ph#* | *Date of Birth* | *SS#* | *Relationship to pt*

Mailing Address (Address/P.O. Box, City, State, and Zip code)
☐ Same as patient

Do you have insurance? ☐ Yes ☐ No **If Yes, we require a copy of the card. Complete the following in order to correctly bill your insurance.*

1. Primary Insurance Co. Name/Address | *Policy#* | *Group#* | *Co-Pay*

Policy Holder Information:
☐ Same as patient ☐ Same as guarantor
Policy Holder's Name *(If not patient or guarantor)*

Policy Holder's Address | *Policy Holder Ph#* | *Relationship to pt* | *DOB* | *Policy Holder SS#*

2. Secondary Insurance Co. Name/Address | *Policy#* | *Group#* | *Co-Pay*

Policy Holder Information:
☐ Same as patient ☐ Same as guarantor
Policy Holder's Name *(If not patient or guarantor)*

Policy Holder's Address | *Policy Holder Ph#* | *Relationship to pt* | *DOB* | *Policy Holder SS#*

The above information is true to the best of my knowledge.

_____

Patient/Authorized Representative Signature | Printed Name | Date

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ACKNOWLEDGEMENT AND AUTHORIZATION FORM

Today Date: _____

Patient Name (Full name):	*Date of Birth:*

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been provided the *Grand Peaks Notice of Privacy Practices (i.e. the "Notice")*. The "Notice" informs me of how Grand Peaks facilities will use my health information for:

- Purposes of my treatment, payment for my treatment and health care operations.
- Reasons other than treatment, payment and health care operations.
- Use and share health information as required/permitted by law.

I have been provided the opportunity to ask questions and understand I may request and review the "Notice" at any time. I understand this agreement will remain in effect until revoked from me in writing.

I authorize Grand Peaks facilities to release health information to the following:

Individual's Name/Facility Name:	Relationship	Phone #(s)/Fax #:
1.		
2.		
3.		
4.		

CONSENT FOR TREATMENT

I hereby authorize Grand Peaks facilities and its affiliated Providers and staff to examine, test, and treat me or my dependent(s) for any medical, dental and/or behavioral/mental health condition. No guarantees have been made to me regarding my treatment or examination. In case of an emergency, in which I cannot be reached, I further authorize Grand Peaks facilities to treat my dependent(s).

AUTHORIZATION FOR ELECTRONIC COMMUNICATIONS

Grand Peaks facilities may communicate with our patients via electronic communications, which may include email, patient portal, and/or text. All communication is kept strictly confidential. Such communications sent thru the internet or over phone systems may not be encrypted or secure and could result in unauthorized persons retrieving your information. Grand Peaks facilities are not responsible for the device that the patient receives communication on (i.e. phone, laptop, tablet, etc.)

AUTHORIZATION FOR FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for any charges incurred and the balance on my account. If I have insurance coverage, I authorize my insurance benefits to be paid directly to the Provider/Upper Valley Community Health Services DBA Grand Peaks facilities. I also authorize Grand Peaks facilities or my insurance company to release any information required to process my claims.

I understand the above policies.

_____

Patient/Authorized Representative Signature Printed Name Date

Relationship to Patient: _____

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APPLICATION FOR SLIDING FEE SCALE / DISCOUNT PROGRAM

Today Date: _____

Our Sliding Fee Scale / Discount program may reduce your cost for services at Grand Peaks Medical, Dental, Behavioral Health, & Pharmacy facilities!

Even if you have insurance, you may qualify for discounts!

MEDICAL, DENTAL & BEHAVIORAL HEALTH DISCOUNTS	***PHARMACY DISCOUNTS***
• Discounts are based on household size & income • Calculation is based on federal guidelines	• All patients are eligible for discounts • You must provide proof of income to qualify

TO QUALIFY FOR DISCOUNTS

1. Apply for the discount(s) by completing this form with your household information.
   - *Note: Medicaid patients MUST complete this form!
2. Provide proof of gross income (copies) for all family members living in the household within ***3 BUSINESS WEEKDAYS*** after the date of this application. (Gross income: income before taxes are with-held.) All income is kept strictly confidential.
   - *Note: We DO require proof of income for Medicare participants.

   To verify your income, we are required to have a copy on file of:
   - 2 Pay-stubs from those working in the household
   - **OR** Disability/Social Security payment statements
   - **OR** Most recent Federal Tax Return showing annual income (Form 1040)
   - **OR** a letter from your employer stating your wages (or a completed *Employment Verification Form*)
   - **OR** a signed letter from someone (not a family member) stating your living situation/income

HOUSEHOLD INFORMATION

HOUSEHOLD MEMBERS' NAME(S)	*DATE OF BIRTH*	*WEEKLY INCOME*	*MONTHLY INCOME*	*ANNUAL INCOME*
Head of Household:				
Spouse/Partner:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Child/Other:				
Total calculated Annual Income:		$	$	$
Total number of family members living in your household (Working and Non-Working):				

TO COMPLETE YOUR APPLICATION FOR DISCOUNTS, PLEASE READ AND SIGN BELOW:

I understand the following:

- If your application is accepted, it will be valid for ONE year.
- I must re-apply annually and provide documentation in order to continue to receive discounted services.
- A payment is due and will be asked for/collected at the time of service.

To the best of my knowledge, the above information is true and correct. I agree to inform Grand Peaks facilities of any changes in my household size, employment or financial status. If the above information proves to be incorrect, the discount will be terminated.

_____

Signature Patient/Authorized Representative *Printed Name* *Date*

*IF YOU DO NOT WISH TO RECEIVE ANY DISCOUNTED SERVICES OR PROVIDE INCOME INFO, PLEASE SIGN:

*I DO NOT wish to provide Grand Peaks with my income. I understand I will be charged **full fees** for all services, including pharmacy/prescriptions, for each visit.*

_____

Signature Patient/Authorized Representative *Printed Name* *Date*

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DENTAL AND MEDICAL HISTORY

Patient's Name:	*Date of Birth:*	*Today's Date:*

DENTAL HISTORY

☐ Bad Breath	☐ Loose teeth/ broken fillings	☐ Sores/ growths in mouth
☐ Bleeding gums	☐ Periodontal treatment	☐ Wear dentures/ partials
☐ Clicking or popping jaw	☐ Sensitivity to hot/cold	☐ Orthodontic Work
☐ Food collection between teeth	☐ Sensitivity to sweets	☐ Head or mouth injury
☐ Grinding teeth	☐ Sensitivity when biting	☐ Dry mouth

How often do you floss? _____ *How often do you brush?* _____

MEDICAL HISTORY

Primary Physician's name: Date of last visit:

Preferred Pharmacy:

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes describe:

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates:

Are you experiencing flu like symptoms: ☐ Yes ☐ No

Do you require antibiotics prior to dental treatment? ☐ Yes ☐ No

Have you had any major surgeries? ☐ Yes ☐ No If yes, please list surgery and date:

Do you have any artificial joints? ☐ Yes ☐ No If yes, please list joint location:

Have you had any organ transplants? ☐ Yes ☐ No If yes, please list organ and date of transplant:

WOMEN: Are you pregnant? ☐ Yes ☐ No If yes, number of weeks pregnant? _____
Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Please check (✓) if you have or have had any of the following:

☐ Anemia	☐ Diabetes	☐ Jaw Pain	☐ Swelling of Limbs
☐ Arthritis, Rheumatism	☐ Epilepsy	☐ Kidney Disease	☐ Thyroid Disease
☐ Asthma	☐ Fainting	☐ Liver Disease	☐ Tobacco Habit
☐ Back Problems	☐ Glaucoma	☐ Mental Health Diagnosis	☐ Tonsillitis
☐ Blood Disease	☐ Headaches	☐ Mitral Valve Prolapse	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur	☐ Pacemaker	☐ Ulcer
☐ Chemical Dependency	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Chemotherapy	☐ Hemophilia	☐ Radiation Therapy	☐ Other:
☐ Circulatory Problems	☐ Hepatitis (Please specify)	☐ Rheumatic Fever	
☐ Cortisone Treatments	☐ A ☐ B ☐ C	☐ Scarlet Fever	
☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath	
☐ Coughing Up Blood	☐ HIV ☐ AIDS		

Please list any medications you are currently taking: *(Please specify dosage and instructions)*	*MEDICATION ALLERGIES*	
1.	☐ Aspirin	☐ Penicillin
2.	☐ Barbiturates (sleeping pills)	☐ Sulfa
3.	☐ Codeine	☐ Tetracycline
4.	☐ Local Anesthetic	☐ Latex
5.	☐ Erythromycin	☐ Metals
6.	☐ Others:	

Patient/Authorized Representative Signature Printed Name Date