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The information in your medical record is confidential and is protected under Massachusetts General Laws Ch. 111 Sec 70.

Medical Record #
(Office use only)
_____

Legal Name * Last	First	Middle Initial	Suffix	**Name used/Nickname:**

Sex at Birth (please check one)* ☐ Female ☐ Male *While CHP recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.	**Preferred Pronoun: (he, she, they, etc.)**

Date of Birth Month Day Year / /	**Social Security #**	**Previous Name (First/Last) / Maiden Name**

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Cell Phone** ( ) **Ok to leave voicemail/text?** ☐ Yes ☐ No	**Work/Day Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Preferred number to call:** ☐ Home ☐ Cell ☐ Work/Day

Mailing/Billing Address	City	State	ZIP

Home Address	City	State	ZIP

☐ CHECK BOX IF SAME AS MAILING ADDRESS

Email Address:

Pharmacy Name	**Pharmacy Street/Town**	**Pharmacy Phone Number**

If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.

Parent/Guardian Full Name	Parent/Guardian DOB / /	Phone Number	Relationship

CHP will send certain notification, such as bills, to your mailing address. How would you prefer to receive other types of notifications? (please check all that apply) ☐ Portal Communications ☐ Phone ☐ Text ☐ Letter ☐ Other:_____

This patient information is for demographic purposes only.

1) Racial Group(s) **(Please check all that apply)** ☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Native American/Alaskan Native/Inuit ☐ Pacific Islander ☐ Other: _____	**2) Ethnicity** **(Please select one)** ☐ Hispanic/Latino Latin ☐ Not Hispanic/Latino Latin **3) Agricultural Worker** ☐ No ☐ Seasonal ☐ Migrant	**4) Preferred Language** **(Please select one)** ☐ English ☐ Español ☐ Français ☐ Português ☐ Русский ☐ Other:_____ **5) US Veteran Status** ☐ Veteran ☐ Not a Veteran ☐ N/A	**6) Employment Status** ☐ Employed full time ☐ Employed part time ☐ Retired ☐ Not employed ☐ Other:_____ **7) Student Status** ☐ Student full time ☐ Student part time

8) Marital Status ☐ Married ☐ Widowed ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Other:_____ **9) Homeless Status** ☐ Not homeless ☐ Doubling up ☐ Homeless Shelter ☐ Transitional ☐ Street ☐ Other _____	**10) What is your sexual orientation?** ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't Know/Decline	**11) What is your current gender?** ☐ Female ☐ Male ☐ Genderqueer or not exclusively male or female **12) What is your gender identity?** ☐ Female ☐ Male ☐ Female-to-Male/Transgender Male ☐ Male-to-Female/Transgender Female ☐ Genderqueer or not exclusively male or female

13) Referral Source (Please check all that apply) ☐ Self ☐ Friend/Family ☐ Health Provider ☐ Emergency Room
☐ Ad/Internet/Media/Outreach/Work/School ☐ Other:_____

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INSURANCE INFORMATION

Please give the front desk your insurance card so that we may have a copy on file. Please complete the insurance information below to ensure billing accuracy. If you have more than 2 insurances please notify the front desk.

Primary Policy Holder Last Name	First name	Middle Initial	Suffix	Date of Birth
Primary Policy Holder Social Security Number	**Phone**		**Email Address**	
- -	( )			
Primary Policy Holder Mailing Address	**City**	**State**		**Zip Code**

Secondary Policy Holder Last Name	First name	Middle Initial	Suffix	Date of Birth
Secondary Policy Holder Social Security Number	**Phone**		**Email Address**	
- -	( )			
Secondary Policy Holder Mailing Address	**City**	**State**		**Zip Code**

Medical/Dental Insurance #1		Medical/Dental Insurance #2	
Insurance Name	**Insurance Plan Type** ☐ Primary ☐ Secondary	**Insurance Name**	**Insurance Plan Type** ☐ Primary ☐ Secondary
Member ID Number	**Plan/Group Number**	**Member ID Number**	**Plan/Group Number**
Effective Date		**Effective Date**	

GUARANTOR INFORMATION

Please fill out the information regarding the person responsible for paying bills not covered by the patient's insurance. This may or may not be the policy holder of the insurance.

☐ **Please check this box if guarantor is the patient and sign below as guarantor.**

Guarantor Last Name	First name	Middle Initial	Suffix	Date of Birth
Guarantor Social Security Number	**Phone**		**Email Address**	
- -	( )			
Guarantor Mailing Address	**City**	**State**		**Zip Code**

Guarantor Signature: _____ Date: _____

Based upon your earnings, you may be eligible for assistance/services that you are not aware of. This information allows CHP to receive valued grant funding which enables us to provide the wide variety of services our patients require.

$10 MINIMAL FEE

1) What is your family's gross income? _____
☐ **Yearly** ☐ **Monthly**
☐ **Every 2 Weeks** ☐ **Weekly**
Family size: _____
2) Please enter head of household:
☐ Self ☐ Other _____

☐ Patient Declined

2020 FEDERAL HHS POVERTY GUIDELINES * (Gross Annual Income) *****

ANNUAL INCOME: FAMILY SIZE	100% & BELOW	101% - 150%	151% - 200%	OVER 200%
1	$ 12,760.00	$ 19,140.00	$ 25,520.00	$ 31,900.00
2	$ 17,240.00	$ 25,860.00	$ 34,480.00	$ 43,100.00
3	$ 21,720.00	$ 32,580.00	$ 43,440.00	$ 54,300.00
4	$ 26,200.00	$ 39,300.00	$ 52,400.00	$ 65,500.00
5	$ 30,680.00	$ 46,020.00	$ 61,360.00	$ 76,700.00
6	$ 35,160.00	$ 52,740.00	$ 70,320.00	$ 87,900.00
7	$ 39,640.00	$ 59,460.00	$ 79,280.00	$ 99,100.00
8	$ 44,120.00	$ 66,180.00	$ 88,240.00	$ 110,300.00
For Each Additional Person Add:	$ 4,480.00			

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INVOLVEMENT IN CARE

I hereby request the following individual(s) be allowed to participate in my care or payment decision process. I understand that this individual(s) may be given health or payment information about me if I am unavailable or unable to communicate. CHP will act on this information until I revoke or amend this authorization in writing. In the event the person listed below is involved in healthcare decisions for me, a health care proxy must be completed.

Full Name	**Relationship**	**Phone** ( )	**Information To Be Released** ☐ All ☐ Medical ☐ Dental ☐ Billing ☐ Appointment Scheduled ☐ Other _____
Full Name	**Relationship**	**Phone** ( )	**Information To Be Released** ☐ All ☐ Medical ☐ Dental ☐ Billing ☐ Appointment Scheduled ☐ Other _____
Full Name	**Relationship**	**Phone** ( )	**Information To Be Released** ☐ All ☐ Medical ☐ Dental ☐ Billing ☐ Appointment Scheduled ☐ Other _____

☐ **Do not disclose any information to any person.**

Patient Signature: _____ Date: _____

CONTACT INFORMATION

Please fill out all pertinent contact information below.

Guardian Last Name	**First Name**	**Middle Initial**	**Suffix**
Guardian Primary Phone ( )	**Cell Phone** ( )	**Work Phone** ( )	

Primary Emergency Contact Last Name	**First Name**	**Relationship**
Emergency Contact Primary Phone ( )	**Cell Phone** ( )	**Work Phone** ( )

Secondary Emergency Contact Last Name	**First Name**	**Relationship**
Emergency Contact Primary Phone ( )	**Cell Phone** ( )	**Work Phone** ( )

Patient's Employer Name	**Employer Full Address**	
Employer's Phone ( )	**Patient Occupation**	**Are you covered under your employer's insurance?** ☐ Yes ☐ No

Patient's School Full Name	**School Full Address**
School Phone ( )	**Are you covered under your school's insurance?** ☐ Yes ☐ No

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Consent for Treatment

Patient Name: _____ Date: _____

I hereby give my consent and authorize Community Health Programs (CHP) to treat any medical, dental, or behavioral health condition providing that the provider has explained the condition to me, the treatment procedures and alternative methods of treating my condition. The provider will/has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which is not known previously.

I understand that CHP integrates medical, dental, nutrition, physical therapy, obstetrics/gynecology, behavioral health, and family services. As a result these additional professionals may be part of my treatment team and experience, which may result in my being seen by these providers and may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient insurance coverage, I will be held responsible for the remaining balance.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all associated CHP visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify for CHP's Sliding Fee Scale via the Sliding Fee Application process administered by CHP's patient assistance enrollment specialist.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that CHP may use data developed for and/or provided by patients to determine general characteristics of the communities it serves; that none of this information will in any way identify individual clients.

I certify that the above information is true and correct. I have been notified of CHP's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature: _____ Date: _____

Guardian/Legal Signature: _____ Date: _____

General Information: Informed consent will be obtained from all patients accessing CHP services. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education. Signature will stay valid unless otherwise revoked by patient in writing.

The patient and/or family, as appropriate, is given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The provider primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

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HEALTH HISTORY

Welcome to our practice. Please fill out the information below to the best of your ability.

Patient Last Name	First Name	Patient DOB: / /	Patient #:	Today's Date: / /
Chief Complaint:				

Past Medical History

Have you ever had the following: (Please check the "No" or "Yes" box where appropriate, leave blank if uncertain.)

Measles ☐ No ☐ Yes	Anemia ☐ No ☐ Yes	Back Trouble ☐ No ☐ Yes	
Mumps ☐ No ☐ Yes	Bladder Infections ☐ No ☐ Yes	High Blood Pressure ☐ No ☐ Yes	Ulcer ☐ No ☐ Yes
Chickenpox ☐ No ☐ Yes	Low Blood Pressure ☐ No ☐ Yes	Kidney Disease ☐ No ☐ Yes	Epilepsy ☐ No ☐ Yes
Whooping Cough ☐ No ☐ Yes	Migraine Headaches ☐ No ☐ Yes	Thyroid Disease ☐ No ☐ Yes	Hemorrhoids ☐ No ☐ Yes
Scarlet Fever ☐ No ☐ Yes	Stroke ☐ No ☐ Yes	Asthma ☐ No ☐ Yes	Diphtheria ☐ No ☐ Yes
Bleeding Tendency ☐ No ☐ Yes	Diabetes ☐ No ☐ Yes	Pneumonia ☐ No ☐ Yes	Smallpox ☐ No ☐ Yes
Cancer ☐ No ☐ Yes	Hives or Eczema ☐ No ☐ Yes	Hepatitis ☐ No ☐ Yes	Polio ☐ No ☐ Yes
AIDS or HIV ☐ No ☐ Yes	Rheumatic Fever ☐ No ☐ Yes	Glaucoma ☐ No ☐ Yes	Hernia ☐ No ☐ Yes
Infectious Mono ☐ No ☐ Yes	Heart Disease ☐ No ☐ Yes	Mitral Valve Prolapse ☐ No ☐ Yes	Bronchitis ☐ No ☐ Yes
Arthritis ☐ No ☐ Yes	Sexually Transmitted Infection(s) ☐ No ☐ Yes	Tuberculosis ☐ No ☐ Yes If Yes, Date of Last X-Ray _____	Blood/Plasma Transfusions ☐ No ☐ Yes
Please list any other disease(s):			

Please list any previous Hospitalizations/Surgeries/Illnesses/Dental Procedures below:

Hospitalization/Surgeries/Illnesses/Dental Procedures:	Date: / /	Hospital Name, City, State
Hospitalization/Surgeries/Illnesses/Dental Procedures:	Date: / /	Hospital Name, City, State
Hospitalization/Surgeries/Illnesses/Dental Procedures:	Date: / /	Hospital Name, City, State

Please list any current medications (including non-prescription) below:

Name and Dosage	Name and Dosage	Name and Dosage	Name and Dosage
Name and Dosage	Name and Dosage	Name and Dosage	Name and Dosage

Patient Social History: Please check the appropriate box next to each topic below:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Use of Alcohol: ☐ Daily ☐ Occasionally ☐ Never
Use of Tobacco: ☐ Daily ☐ Occasionally ☐ Never Previously, but quit: Current packs per day:
Use of Vaping: ☐ Daily ☐ Occasionally ☐ Never Previously, but quit: Current pods/cartridges per day:
Use of Drugs(including marijuana): ☐ Daily ☐ Occasionally ☐ Never Previously, but quit:
Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-borne Particles ☐ Noise

Family Medical History – Please fill out all applicable information below:

Father	Age	Diseases	If Deceased, Cause of Death
Mother	Age	Diseases	If Deceased, Cause of Death
Sibling	Age	Diseases	If Deceased, Cause of Death
Spouse	Age	Diseases	If Deceased, Cause of Death
Children	Age	Diseases	If Deceased, Cause of Death

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Review of Systems – Pediatric (Female)

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

In the past month have you had or do you currently have:

Constitutional ☐ All Not Applicable

YES	NO		YES	NO	
☐	☐	chills	☐	☐	fussiness
☐	☐	decreased activity	☐	☐	irritability
☐	☐	decreased appetite			
☐	☐	weight gain (more than 10lbs.)			
☐	☐	weight loss (more than 10lbs.)			
☐	☐	fever			

Duration: _____ Tmax: _____

☐ ☐ lethargy (lack of energy/enthusiasm)

Other: _____

Respiratory ☐ All Not Applicable

YES	NO	
☐	☐	difficulty breathing (dyspnea)
☐	☐	stridor (wheezing)
☐	☐	use of accessory muscles
☐	☐	cough?

Quality: _____ Frequency: _____

☐	☐	known TB exposure
☐	☐	sputum
☐	☐	wheezing (TB risk factor)

Other: _____

Gastrointestinal (Abdomen)
☐ All Not Applicable

YES	NO	
☐	☐	abdominal pain
☐	☐	constipation
☐	☐	diarrhea
☐	☐	nausea
☐	☐	reflux
☐	☐	vomiting

Other: _____

HEENT ☐ All Not Applicable

YES	NO	
☐	☐	difficulty swallowing (dysphagia)
☐	☐	ear discharge
☐	☐	cross-eyed appearance (esotropia)
☐	☐	eye discharge
☐	☐	eye redness
☐	☐	headaches
☐	☐	hearing loss
☐	☐	nasal congestion
☐	☐	ear pain (otalgia)
☐	☐	sore throat (pharyngitis)
☐	☐	runny nose (rhinorrhea)
☐	☐	sneezing
☐	☐	tearing
☐	☐	vision loss

Other: _____

Cardiovascular (Heart/Circulation)
☐ All Not Applicable

YES	NO	
☐	☐	chest pain
☐	☐	irregular heartbeat/palpitations
☐	☐	temporary loss of consciousness (syncope)

Other: _____

Hematologic ☐ All Not Applicable

YES	NO	
☐	☐	easy bleeding
☐	☐	easy bruising
☐	☐	enlarged lymph nodes (lymphadenopathy)
☐	☐	bleeding under the skin (petechiae)

Other: _____

Genitourinary (Kidneys & Bladder)
☐ All Not Applicable

YES	NO	
☐	☐	decreased urine output
☐	☐	painful urination (dysuria)
☐	☐	uncontrolled urination (enuresis)
☐	☐	flank pain
☐	☐	foul urine odor
☐	☐	blood in urine (hematuria)
☐	☐	excessive urination (polyuria)

Other: _____

Integumentary (Skin) ☐ All Not Applicable

YES	NO	
☐	☐	acne
☐	☐	rash
☐	☐	itchy skin (pruritis)

Other: _____

Reproductive (Female) ☐ All Not Applicable

YES	NO	
☐	☐	menstrual cramps (dysmenorrhea)
☐	☐	heavy menstrual flow (menorrhagia)
☐	☐	vaginal discharge
☐	☐	vaginal itching

Menarche age: _____ Last Menses: _____
☐ regular ☐ irregular
Frequency: _____ Flow: ____/___/_____
Contraception: ☐ Yes ☐ No
Type: _____

Other: _____

Metabolic/Endocrine ☐ All Not Applicable

YES	NO	
☐	☐	excessive thirst (polydipsia)
☐	☐	excessive urination (polyuria)
☐	☐	abnormal sleep pattern

Other: _____

Vascular ☐ All Not Applicable

YES	NO	
☐	☐	cool extremity
☐	☐	bluish cast to the skin (cyanosis)

Other: _____

Musculoskeletal ☐ All Not Applicable

YES	NO	
☐	☐	bone pain
☐	☐	joint paint
☐	☐	joint swelling
☐	☐	muscle weakness
☐	☐	myalgia

Other: _____

Neuro/Psychiatric ☐ All Not Applicable

YES	NO	
☐	☐	inappropriate interaction
☐	☐	behavioral changes
☐	☐	inconsolable
☐	☐	difficulty concentrating
☐	☐	distorted body image
☐	☐	self conscious
☐	☐	abnormal sleeping patterns

Other: _____

Immunological (Immune System)
☐ All Not Applicable

YES	NO	
☐	☐	allergic rhinitis (seasonal allergies)
☐	☐	environmental allergies
☐	☐	food allergies
☐	☐	urticaria

Other: _____

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PLEASE FILL OUT THE SOCIAL NEEDS SCREENING THAT APPLIES TO THE PATIENT

Pediatric Social Needs Screening (0 – 17 years of age)

Because we care, this questionnaire is used to help understand your needs.
Based on the answers, we may be able to provide information on resources available to you.

Patient Full Name	**Patient Date of Birth** / /	**Date of Questionnaire** / /

1. In the past year, has your child been unable to get any of the following when it was really needed? (Please select one answer to each question).

Food
☐ Yes ☐ No ☐ Unclear ☐ I choose not to answer this question.
Clothing
☐ Yes ☐ No ☐ Unclear ☐ I choose not to answer this question.
Utilities (heat, electricity, etc.)
☐ Yes ☐ No ☐ Unclear ☐ I choose not to answer this question.
Medicine or any health care need (medical, dental, mental health or vision)
☐ Yes ☐ No ☐ Unclear ☐ I choose not to answer this question.
Other (please specify): _____
☐ Yes ☐ No ☐ Unclear ☐ I choose not to answer this question.

2. Are you worried about losing current housing for your child?
☐ Yes
☐ No
☐ Unclear
☐ I choose not to answer this question.

3. Has lack of transportation kept you from getting your child to medical appointments, school or from getting things needed for daily living?
☐ Yes, it has kept my child from medical appointments or from getting their medications.
☐ Yes, it has kept my child from non-medical meetings, school or getting things needed for daily living.
☐ No
☐ Unclear
☐ I choose not to answer this question.

4. Do you believe that your child feels emotionally and physically safe at home, school, and in the community?
☐ Yes
☐ No
☐ Unclear
☐ I choose not to answer this question.

5. Does your child attend school regularly?
☐ Yes
☐ No
☐ Unclear
☐ I choose not to answer this question.

6. Does your child ever feel alone or isolated from friends, family or anyone else in their life?
☐ Yes, my child does feel alone or isolated.
- How often? (please check one selection below)
  ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

☐ No, my child does not feel alone or isolated.
☐ Unclear
☐ I choose not to answer this question.

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PATIENT RIGHTS AND RESPONSIBILITIES

As a patient, you have the right to:

- Take part in your health care and treatment
- Know the names of the people caring for you
- Be treated with respect and dignity in a safe and private setting
- Be informed about your illness and treatment, including options for your care
- Change medical providers at Community Health Programs (CHP)
- Obtain another opinion about your illness or treatment
- Privacy of your health records
- Talk with the clinical manager about any questions or problems with your care
- Know about services available through Community Health Programs (CHP)
- Respect of your cultural, social, spiritual, and personal values and beliefs
- Know about legal reporting requirements
- Request special accommodations if you have a disability
- Request assistance with a living will or durable power of attorney for health care
- Refuse treatment, care, and services as allowed by law
- Be aware of the cost of your care and ways you may pay for your care
- Refuse to be included in any research program without limiting medical care or treatment

As a patient, you have the responsibility to:

- Inform your medical provider about your illness or problems
- Ask questions about your illness or care
- Show respect to both care givers and other patients
- Cancel or reschedule appointments a minimum of 24 hours prior so that another person may receive care in that time slot
- Pay your copayment and bills on time
- Use medications or medical devices for personal use only
- Inform the medical provider if you become worse or have an unexpected reaction to a medication
- Provide at least 48 hours' notice for prescription refills which may take longer for certain medications. **Note:** Prescriptions are NOT refilled after hours, on weekends, or holidays. **NARCOTICS ARE NOT PRESCRIBED WITHOUT AN APPOINTMENT**
- Provide written permission to release your other health records to Community Health Programs, Inc. (CHP) when necessary
- Provider Community Health Programs (CHP) a copy of your living will or durable power of attorney for health care matters

Additional Information:

- After Hours Care: We have 24-hour on-call coverage through an answering service. If your call is regarding an appointment, referral, billing or prescription refill, we ask that you call during normal operating hours.
- Forms: We are happy to fill out physical forms, camp forms, college forms if you have had your yearly physical. Please give the office at least one week to complete and return the forms to you. Otherwise, you may bring them with you at your physical appointment.

If you have any questions, please tell your medical provider or the clinical manager.
(For patient awareness, please take this page home with you)