Community Health Center CHC

107 Commercial Street
Mashpee, MA 02649
508-477-7090
508-477-7028 (fax)
CHCofCapeCod.org

Welcome to your new medical home! We are excited to offer you high quality, integrated health care services including medical, dental, behavioral health, optometry, pharmacy, and so much more!

Please follow these easy admission steps to become a patient:

1. Apply for health insurance if necessary (we must have verification that you have applied for insurance before we can schedule you for an appointment). If you need assistance applying for health insurance, we can help. Assistance is available according to the schedule at the end of this sheet.
2. Complete and return (drop off, fax or mail) the registration forms:
    - New Patient Registration
    - New Patient Intake
    - Social Needs Screen
    - Forms to Request and Share Information
3. Read our Patient Information Guide and Notice of Privacy Practices online, or request a copy from one of our offices. (https://chcofcapecod.org/welcome-to-chc/ and https://chcofcapecod.org/about-us/privacy-policy/)
4. Sign up for our patient portal, MyChart. MyChart will allow you to communicate with your care team, view your medical records, and request referrals and medication refills. You will receive a text message or email inviting you to join the Epic MyChart portal when we set up your chart. Please visit our website or call us for more information.

Once we have completed your registration, usually within 5 business days of receiving your forms, you will receive a text message or recorded call inviting you to schedule your first appointment. Please respond to the text or call us at 508-477-7090 and press 0 for an operator during business hours to schedule the appointment, or if you need additional assistance.

Sincerely,

Karen Gardner
Chief Executive Officer

Health Insurance Application Assistance
We generally have staff available Monday - Friday, 9 a.m. - 4 p.m. to assist with health insurance applications. It is best to call ahead (508-477-7090) to be sure someone is available to help you. If you have any questions about health insurance applications, please contact our Outreach Coordinator, at 508-477-7090, ext. 1155

Community Health Center ~ New Patient Registration Form –- please complete in black ink Nov-22

Preferred primary location: □*Mashpee* □*Falmouth* □*Bourne* □*Sandwich* □*Centerville*

I am registering for the following Services: □Primary Care ☐Walk-in only ☐Dental ☐Gynecology ☐ Substance Use Disorder Treatment

☐Vision ☐Behavioral Health***** (*****You must be a Primary Care patient at CHC to access Behavioral Health services)

If you receive Primary Care elsewhere, please provide name & phone for your PCP:_____

Patient Last Name:	Patient First Name:	SSN:	Date of Birth:	Sex (legal): □M □F

Title:	Middle Name:	Preferred Name/Nickname:	Maiden Name:	Other names or aliases:

Mailing Address:	City:	State:	Zip Code:
Home Address (if different from Mailing):	City:	State:	Zip Code:

PHONE & EMAIL Please provide number where you prefer to receive calls or text messages & where we may leave a message for you.

Phone (_____) _____ Patient E-mail: _____

This is my: □Mobile □Home □Work □Other _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Domestic Partner ☐Separated ☐Widowed

Ethnicity – check one □Mexican/Mexican American/Chicano □Puerto Rican □Cuban □Puerto Rican □Other Hispanic, Latino/a, or Spanish Origin □Not Hispanic, Latino/a, or Spanish Origin □Choose not to disclose

Race - Check as many as apply: □White □Asian Indian □Chinese □Filipino □Japanese □ Korean □Vietnamese □Other Asian □Native Hawaiian □Samoan □Other Pacific Islander □Guamanian or Chamorro □Black/African American □American Indian/Alaska Native □Choose not to disclose

Sex assigned at birth: ☐M ☐F

Sexual Orientation: □Straight or Heterosexual □Bisexual □Something else □Don't' know □Choose not to disclose □Gay □Lesbian □Pansexual □Queer

Gender Identity: □Male □Female □Transgender Female/Male to Female □Transgender Male/Female to Male □Other □Choose not to disclose □Nonbinary/genderqueer □Questioning

Pronoun: □she/her/hers □he/him/his □they/them/theirs □ze/hir/hirs □ey/em/eirs □xe/xem/xyrs □ve/vir/vis □other □my name □decline to answer

Is patient a US VETERAN? ☐Yes ☐No

Country of Birth - ☐US ☐Brazil ☐Cape Verde ☐Jamaica ☐_____

EMERGENCY CONTACT Name:_____ Phone Number: (_____)_____

Relationship to patient:

PARENT/GUARDIANSHIP: please complete for Patients under age 18 and patients with Legal Guardian

Does the patient have a Legal Guardian, other than a parent? ☐Yes ☐No **If Yes, Please attach Guardianship paperwork.**

Name of Parent/Guardian:_____ Relationship to Patient _____

Parent/Guardian Phone Number: (_____)_____ Parent/Guardian SSN:_____

PATIENT EMPLOYER:	PATIENT OCCUPATION:

PATIENT EMPLOYMENT STATUS: Are you a seasonal or migrant worker? □ Yes □ No

□Full-time □Not employed □Part-time □Retired □Active Military □Self-employed □Student FT □Student PT

Is Patient visually impaired? □Yes □ No Is Patient hearing impaired? □Yes □ No

Primary Language if not English:_____ Interpreter needed? □Yes □ No

How did you hear about us?: ☐ Friend ☐Employer ☐ Social Service Agency ☐Hospital ☐Doctor ☐Newspaper ☐TV ☐Radio ☐Online search ☐Online ad ☐CHC postcard ☐CHC brochure ☐Other _____

For grant reporting purposes only. No personally identifiable information is ever reported. This section helps us to receive funding

How many people are in your household: _____ What is the annual income for your household:_____

MEDICAL INS ID# _____ Primary

MEDICAL INS ID# _____ Secondary if applicable

Insurance (check all that apply): □ No Insurance □Applied □Mass Health (C3) □HSN □Medicare □Harvard Pilgrim □BC/BS □ Tufts □Tricare □United Health □Veterans □Other:_____

Are you a member of Indian Health Services? ☐Yes ☐No

Subscriber info (if insurance subscriber is not the patient):

Name_____ Date of Birth_____

Dental Insurance _____ ID #_____

Dental Insurance _____ ID #_____

Vision Insurance_____ ID #_____

Vision Insurance_____ ID #_____

SIGNATURE (Patient or Parent/Guardian): Date:

Date received by CHC:	*Office/PCP assigned:*	*CHC Staff initials accepting packet/date:*

Community Health Center CHC

NEW PATIENT INTAKE FORM MAR 2022

Name *(Last, First, M.I.):*	Date of Birth:	Date Completed:

MEDICATIONS

Please list any medications that you are currently taking and reason for that medication. *Place a checkmark next to any that needs refills.*

Refill needed?	Medication	Reason for medication	Refill needed?	Medication	Reason for medication
☐			☐		
☐			☐		
☐			☐		
☐			☐		

Please list any allergies to medications or any other allergies:

Please check here if you do not have any medication allergies ☐ Please check here if you are not on any medications ☐

RECENT HISTORY

Name of Previous Physician:	Phone:		
Have you been seen in the ER in the last 10 days?		☐ Yes	☐ No
Have you been an inpatient at a hospital, rehab, detox or nursing facility in the last 21 days?		☐ Yes	☐ No
Do you have any URGENT medical needs that require you to be seen immediately?		☐ Yes	☐ No
Please explain briefly:			
Who is your health care proxy? (Please provide us with a copy of the document):			
Do you have an advance directive document? (Please provide us with a copy)		☐ Yes	☐ No
Have you seen a specialist recently? (i.e. Neurologist, Orthopedist, Cardiologist, Behavioral Health, etc.)		☐ Yes	☐ No
Do you have thoughts of hurting yourself or others?		☐ Yes	☐ No
Would you like to see a counselor?		☐ Yes	☐ No
For pediatric patients: is the patient in need of immunizations or a time-sensitive physical?		☐ Yes	☐ No
Do you need an antibiotic prior to dental treatment? (eg joint replacement, artificial heart valve)		☐ Yes	☐ No
Have you ever had any complications following dental treatment?		☐ Yes	☐ No
If yes, please explain:			

HEALTH ISSUES

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Rheumatic Fever	☐ Pregnancy, Due Date:
☐ Anxiety	☐ Fainting	☐ Radiation Treatment	☐ Rheumatic Fever
☐ Ability to sleep	☐ Growths	☐ Liver Disease	☐ Sexually Transmitted Infection
☐ Arthritis	☐ Hay Fever	☐ Pacemaker	☐ Sinus Problems
☐ Asthma/Emphysema	☐ Heart Disease/ Heart Attack	☐ Ulcers	☐ Stroke
☐ Artificial Joints	☐ Heart Murmur	☐ Glaucoma	☐ Thyroid disease
☐ Blood disease	☐ Hepatitis	☐ Throat	☐ Tuberculosis
☐ Cancer	☐ High Blood Pressure	☐ Rheumatism	☐ Tumors
☐ Depression	☐ Jaundice	☐ Lungs	☐ Vision problems
☐ Diabetes	☐ Kidney Disease	☐ Stomach Problems	☐ Other
☐ Dizziness	☐ Respiratory Problems	☐ Head injuries	
☐ Epilepsy	☐ Alcohol / Drug Dependency (past or present)	☐ Mental Disorders	

Signature:_____ Date:_____

Community Health Center CHC

Name		Date of Birth		Today's Date	

Social Needs Screen

Directions: Please fill out all the questions, whether you are answering for yourself or for a child, so that your care team has the most complete information to care for you.

1. What is your housing situation today?

- ❑ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
- ❑ I have housing today, but I am worried about losing housing in the future
- ❑ I have housing
- ❑ I am not sure

2. Think about the place you live. Do you have problems with any of the following?
(Check all that apply)

- ❑ Pests such as bugs, ants, or mice
- ❑ Mold
- ❑ Lead paint or pipes
- ❑ Inadequate heat
- ❑ Oven or stove not working
- ❑ No or not working smoke detectors
- ❑ Water leaks
- ❑ None of the above
- ❑ I am not sure

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ❑ Often true
- ❑ Sometimes true
- ❑ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have enough money to get more.

- ❑ Often true
- ❑ Sometimes true
- ❑ Never true

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
(Check all that apply)

- ❑ Yes, it has kept me from medical appointments or getting medications
- ❑ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
- ❑ No
- ❑ I am not sure

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ❑ Yes
- ❑ No
- ❑ Already shut off
- ❑ I am not sure

7. Think about the place you live. Do you have access to internet/wifi when you need it?

- ❑ Yes
- ❑ No…If no, why not? (Check all that apply)
  - o I cannot afford it
  - o Internet/wi-fi access is not available where I live
  - o My internet/wi-fi access is not consistent or reliable
  - o I do not want or need it
- ❑ I am not sure

8. Would you like help with any of the needs that you have identified?

- ❑ Yes
- ❑ No

Dear Patient, Please complete separate Authorization for Release of Protected Health Information forms for each provider who has medical records for you from the past 7 years if you are over 25 years old and for the past 10 years if you are 24 or younger. Additional forms can be downloaded from chcofcapecod.org or picked up any of our office locations. Please initial all of the items in the RELEASE OF SENSITIVE INFORMATION section to ensure we get your complete medical records.

Community Health Center CHC

REQUEST MY RECORDS: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

107 Commercial Street, Mashpee MA 02649
Phone (508) 477-7090 Fax (508) 477-7028

Patient Last Name:	Patient First Name:	Middle Initial:	Date of Birth:

Patient Mailing Address:	Patient Phone:

I authorize Community Health Center to request my medical records from

Name/Facility:	Phone:	Fax:

Street:	City:	State:	Zip

Medical records include information pertaining to my identity, prognosis, diagnosis, or treatment
Information to be released:

☒ My Entire Record

RELEASE OF SENSITIVE INFORMATION – Please initial to ensure your complete records are released

Under Massachusetts state law we cannot release certain information unless you give us special permission to release it.
By initialing each item I agree to its release:

___HIV/AIDS information (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST WITH SPECIFIC DATES)
___Details of Domestic Violence Victims' Counseling
___Details of Sexual Assault Counseling
___Details of Mental Health Diagnosis and/or treatment provided by a Mental Health Provider (I understand that my permission may not be required to release my mental health records for payment purposes)
___Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon written request

This authorization is valid for release of Protected Health Information for 180 days from date below OR (please indicate):

❑ a one-time disclosure ❑ upon termination from services ❑until revoked ❑other_____

I understand that by law, I do not need to consent to the release of/request for this information to receive care or payment for care or to be eligible for enrollment or any benefits. However, I choose to do so willingly and voluntarily for the purpose specified above. My signature acknowledges my receipt and understanding of CHC of Cape Cod Notice of Privacy Practices. I understand that I have the right to request a copy of my records as provided by CFR 164.524. I understand that I have a right to receive a copy of this form after I have signed it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Manager.

I understand that I may revoke this authorization in writing. Upon revocation, information will not be released except to the extent that we have already taken action in response to this authorization.
I also release Community Health Center of Cape Cod from all legal responsibilities and liabilities that may arise from the release of the information.

Signature of Patient/personal representative:_____ Date:_____

If signed by anyone other than patient, print name and select relationship and/or reason and legal authority to do so

Name:_____
Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness:_____ Date:_____

Dear Patient, Please complete separate Authorization for Release of Protected Health Information forms for each provider who has medical records for you from the past 7 years if you are over 25 years old and for the past 10 years if you are 24 or younger. Additional forms can be downloaded from chcofcapecod.org or picked up any of our office locations. Please initial all of the items in the RELEASE OF SENSITIVE INFORMATION section to ensure we get your complete medical records.

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Patient Mailing Address:	Patient Phone:

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If signed by anyone other than patient, print name and select relationship and/or reason and legal authority to do so

Name:_____
Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness:_____ Date:_____

Dear Patient (Parent or Guardian), If there is an individual (eg family member, advocate, etc) you would like to grant CHC permission to discuss your care, make appointments, share your medical information with, and in the case of minor patients accompany your child to visits, please complete and sign this Authorization to Release Protected Health Information form with their information. Thank you!

Community Health Center CHC

SHARE MY RECORD: AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

107 Commercial Street, Mashpee MA 02649
Phone (508) 477-7090 Fax (508) 477-7028

Patient Last Name:	Patient First Name:	Middle Initial:	Date of Birth:

Patient Mailing Address:	Patient Phone:

I authorize Community Health Center to SHARE my medical records with

Name/Facility:	Phone:	Fax:

Street:	City:	State:	Zip

Medical records include information pertaining to my identity, prognosis, diagnosis, or treatment
Information to be released:

☒ My Entire Record

RELEASE OF SENSITIVE INFORMATION – Please initial to ensure your complete records are released

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Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness:_____ Date:_____

Community Health Center CHC

Pharmacy Services

- Conveniently located on-site in our Mashpee, Falmouth and Bourne offices.
- Pick-up your prescription while you are at Community Health Center for one-stop convenience!
- The mobileRx app helps manage prescriptions - you will receive a text when your prescription is ready.
- Our Pharmacy team communicates regularly with your provider and care team.
- Vaccine administration is available.
- Bourne and Falmouth Pharmacy services are available to CHC patients and non-CHC patients alike.

Masphee: 107 Commercial Street (508) 477-0004
Falmouth: 200 Jones Road, Homeport (508) 681-7399
Bourne: 123 Waterhouse Road (508) 539-6090

SCAN ME

To have your prescriptions filled at a CHC Pharmacy, simply talk to your care team!