Nasson Health Care
a division of York County Community Action Corporation

MAILING ADDRESS
15 Oak Street | Springvale, ME 04083

LOCATIONS
15 Oak Street | Springvale, ME 04083
357 Elm Street | Biddeford, ME 04005

P: (207) 490-6900 | F: (207) 459-2822
NassonHealthCare.org

PRE-APPOINTMENT FORMS CHECK LIST

Welcome to Nasson Health Care! In order to facilitate the registration process, and to save you time on the day of your appointment, we ask that you bring in or mail **all the completed forms** listed below.

Please mail or bring with you to: **Nasson Health Care**
15 Oak Street | Springvale, ME 04083

When you come in for your first appointment, please bring all current medication bottles with you.

Pages 2 & 3 **REGISTRATION FORM**
Please fill out completely and remember to sign it.

Pages 4 & 5 **HEALTH HISTORY QUESTIONNAIRE**
Please fill out both front and back of the form.

Page 6 **HOUSEHOLD DATA**
When filling out this form, income needs to be included; this is confidential and does not affect sliding fee scale determination. This form needs to be filled out completely so we can continue to fulfill our grant requirements.

Please read the forms carefully. If you should have any questions, please don't hesitate to call us at (207) 490-6900.

Our goal is to exceed your expectations each time you visit our office. In order to provide an efficient, productive patient experience, we prepare and review as much information as possible prior to your arrival.

Thank you,

Nasson Staff Team

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REGISTRATION FORM (Please Print)

Date _____ Check all services you are interested in: ☐ Medical ☐ Dental

Notification Preferences (Check ALL that apply)
☐ Email ☐ Phone Call
☐ Portal ☐ SMS Text
☐ Voice Mail

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ ☐ Sr. ☐ Jr.

Previous Name(s) _____

Date of Birth ____ /____ /_____ **Patient's** Social Security Number _____

Street Address _____ City_____ State _____ Zip Code _____

PO Box _____ City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email address _____ Mother's maiden name_____

Marital Status (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Current Employer Name_____ Employer Phone Number_____

Employer Address _____

Please complete ***(if Patient is a minor, is incapacitated, and/or otherwise authorized third party to make health care decisions for the patient)***

Parent/Authorized Representative _____ ☐ Legal Parent/Guardian ☐ Foster Parent ☐ Other _____

Parent/Authorized Representative Date of Birth ____ /____ /_____

HEALTH INSURANCE

☐ Yes ☐ No Please provide copies of your insurance cards (you may also text copies (front/back) of your cards to 207-490-6900)

Insurance Type ☐ Maine Care ☐ Medicare A ☐ Medicare B ☐ Commercial ☐ Other _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder SS# _____ Relationship to policy holder _____

Name of Insurance _____ Insurance ID# _____ Group #_____

Name of Insurance _____ Insurance ID# _____ Group #_____

Insurance Claims Address (on the back of the insurance card)

_____

DENTAL INSURANCE

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder SS# _____ Relationship to policy holder _____

Name of Insurance _____ Insurance ID# _____ Group #_____

Patient Name _____ Date of Birth ____ /____ /____

PHARMACY 1

Name	Town

PHARMACY 2

Name	Town

PERSONS/FAMILY MEMBERS INVOLVED IN YOUR CARE

I give permission to share health information about my treatment received at this facility to the below listed person(s)

Name _____ Relationship _____ Phone number _____

Name _____ Relationship _____ Phone number _____

EMERGENCY CONTACT / SUPPORT ROLE

Please notify person listed below	Relationship to patient	Home phone number	Home, Cell or Work phone

CONSENT

- I am personally responsible for providing accurate and current insurance information.
- I authorize my insurance benefits to be paid directly to the physician at Nasson Health Care.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that I am financially responsible for any remaining balance.
- I consent for medical images to be made of me (photo, video and/or audio) to be used in my medical record, and/or for diagnosis and treatment purposes. Refusal to consent will in no way affect the medical care I receive.
- I understand that signing this form permits me to receive all services provided by Nasson Health Care. These services include diagnosis and treatment of acute illnesses, mental health services, and reproductive health services.

I certify that the above information is true and correct to the best of my knowledge.

_____ Date: _____

Patient Signature

OR, If Applicable:

Parent's Name/ Authorized Representative's Name_____

Address_____

Authority under State Law (e.g., parent, guardian, health care power of attorney) _____

Signature_____ Date_____

Authorized Representative's Documentation Received ☐ Yes ☐ No

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.	
Name (Last, First, M.I.): ☐ M ☐ F	DOB:

Primary Care Provider	**Date of last physical exam**

PERSONAL HEALTH HISTORY

List any medical problems that have been diagnosed, surgeries and hospitalizations
Have you been tested for TB in the past 6 months? ☐ Yes ☐ No If yes, were results positive or negative?
FEMALES: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Are you breast feeding? ☐ Yes ☐ No Are you taking oral contraceptives ☐ Yes ☐ No

TOBACCO	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – packs per day	☐ Chew - #/day	☐ Pipe - #/day	
	☐ Vape – #/day		☐ Number of years	
Substance Abuse	Do you have a history of substance abuse or do you currently have a substance abuse problem? (Drugs, alcohol, etc.)		☐ Yes	☐ No
Personal Safety	Have you ever been verbally, sexually, or physically hurt by anyone?		☐ Yes	☐ No
	Do you currently feel safe in your environment?		☐ Yes	☐ No

ALLERGIES: Including Acrylic, Metal, Latex and Local Anesthetics

Name the source:	**Reaction:**

Name: _____ DOB: _____

MEDICATIONS

Preferred Pharmacy:		
Name of Medication:	**Strength:**	**Frequency taken:**

FILL OUT THIS SECTION ONLY IF YOU WILL BE ESTABLISHING WITH A BEHAVIORAL HEALTH PROVIDER OR A DENTAL PROVIDER

FOR BEHAVIORAL HEALTH CARE

MENTAL HEALTH HISTORY

Please list mental health providers you have seen in the last five (5) years		
Provider Name	**How long you were seen**	**Reason you were seen**

FOR DENTAL HEALTH CARE

DENTAL HEALTH HISTORY

Do you have a current problem? (pain, swelling, sensitivity, broken tooth etc.) ☐ Yes ☐ No	
If Yes, please describe:	
When was your last dental visit?	Dentist's Name:
What type of treatment was performed?	

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The information in your mdical record is confidential and is protected under Maine Revised Statutes Title 22, Section 1711-C. Your written consent will be required for release of information except in the case of a court order.

HOUSEHOLD & PERSONAL INFORMATION

Nasson Health Care relies on federal funding to make our services available to everyone. Your answers to these questions help us continue to receive that funding. Thank you.

LEGAL NAME: _____ **DOB:** _____ **DATE:** _____

PREVIOUS NAME(S) _____

Do you speak English? □ Yes □ No If no, what language do you speak? _____

Race:
□ American Indian/Alaska Native
□ Black/ African American
□ Native Hawaiian
□ White
□ Chinese
□ Asian
□ Asian Indian
□ Other Asian
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Guamanian
□ Chamorro
□ Samoan
□ More than one race
□ Unreported/Refused to report race

Ethnicity:
□ Not Hispanic or Latino
□ Mexican
□ Chicano/a
□ Cuban
□ Hispanic or Latino
□ Mexican American
□ Puerto Rican
□ Decline to Specify
□ Other
□ Unknown

Are you a migrant worker or seasonal farm worker? □ Yes □ No

Are you a Veteran? □ Yes □ No

Birth Sex
□ Male
□ Female

Gender Identity
□ Male
□ Female
□ Female to Male - Transgender
□ Male to Female – Transgender
□ Genderqueer, neither exclusively male nor female
□ Other _____
□ Choose not to disclose

Sexual Orientation
□ Straight – not lesbian or gay
□ Lesbian or gay
□ Bisexual
□ Something else
□ Don't know
□ Choose not to disclose

Preferred Pronoun
□ He, Him, His
□ She, Her, Hers
□ They, Them, Theirs
□ Ze, Hir
□ Other
□ Decline to answer
□ Asked but unknown

Housing Status:

Rent: □ Yes □ No Public Housing □ Yes □ No Is rent based on income? □ Yes □ No
Own Home: □ Yes □ No
Homeless Shelter: □ Yes □ No
Transitional Housing: □ Yes □ No
Doubling Up: □ Yes □ No
Other: _____

Household: List the people who live with you (List additional people on back of form)

Last Name	First Name	Date of Birth	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Confidential Household Income: (You plus spouse.)
$ _____ Check one: □ Weekly □ Monthly □ Yearly