



Eastport Health Care, Inc.

Our Specialty is YOU!

Rowland B. French Medical Center
Vogl Behavioral Health Center
30 Boynton Street
Eastport, Maine 04631
Phone: 207-853-6001
Fax: 207-853-6180

Welcome to EHC!

Thank you for your interest in becoming our patient! Our goal is to provide high quality health care and we are excited to be your Patient Centered Medical Home.

Please complete and return the enclosed documents to our office to begin the process of becoming our patient. All forms must be filled out as completely as possible. **Missing documents or incomplete forms will be sent back to you which will delay your initial appointment.**

1. Registration form
2. Authorization to Release Health Information form (This is required for us to request past medical records. Our providers must review past medical records before deciding if they are able to accept you as a patient.)
3. Health History form

This process could take anywhere between 3-6 weeks to obtain all of the necessary information and present it to a provider. Once we receive all of the necessary information, a provider has 7 business days to review your information. If one of our providers can provide your care, our reception staff will contact you to schedule an initial appointment. In the event a provider is not able to provide your care, we will provide you with information for other local medical providers.

If you have any questions or concerns, please contact us at any of our office locations.

Eastport Health Care, Inc. is an Equal Opportunity Employer and Provider

Machias Behavioral Health
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-3400
Fax: (207)-255-3401

Machias Family Practice
160 Dublin St.
Machias, ME 04654
Phone: (207)-255-8290
Fax: (207)-255-4109

Machias Pediatrics
160 Dublin St.
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Phone: (207)-255-0980
Fax: (207)-255-3897

Kulasihkulpon peciyayin EHC! (Passamaquoddy)

Woliwon eli-tpitahatomon kiseltomuwinen ktankeyulonen! Npawatomonen kulankeyulonen, naka nulitahasipon eli yut-oc kil ktaspihtolom.

Mec-op-al kisi-psonehtun naka ktapaciptun ntahpisomonnuk yuhtol wikhikonol, weci-kisi-mace luhkatomek eli-koti-mace-ankeyuwulek. Psi-te pilaskul cuwi-'kihka-psonehtasuwol.

Keskahtasikil pilaskul naka wikhikonol skat nekka-psonehtasinuhk cu-oc wesuwe-pcitahkewkenol, nakahc amsqahs keti-nemiyukiyin-oc metsiyewiw.

Nehehtaw iyyin qecikesuwakonol kosona 'tomitahasuwakonol, mec-op-al kisi-mattoktehtumuwinen tan-ote ehtek ntahpisomonnul.

Bienvenue chez EHC ! (French)

Merci de vouloir devenir l'un de nos patients ! Notre objectif est de fournir des soins de santé de haute qualité et nous sommes heureux d'être votre maison médicale centrée sur le patient.

Veillez remplir et renvoyer les documents ci-joints à notre bureau afin d'entamer votre procédure d'inscription en tant que patient. Tous les formulaires doivent être remplis aussi complètement que possible. Les documents manquants ou les formulaires incomplets vous seront renvoyés, ce qui retardera votre rendez-vous initial.

1. Formulaire d'inscription
2. Formulaire d'autorisation de divulgation de renseignements médicaux. (Nous en avons besoin pour demander des antécédents médicaux. Nos prestataires doivent examiner vos antécédents médicaux avant de décider s'ils sont en mesure de vous accepter en tant que patient.)
3. Formulaire de l'historique de santé.

Lorsque nous aurons reçu toutes les informations nécessaires, un prestataire dispose de 7 jours ouvrables pour examiner vos informations. Si vous êtes accepté comme patient, notre personnel d'accueil vous contactera pour fixer un premier rendez-vous. Dans le cas où un prestataire ne serait pas en mesure de vous accepter en tant que patient, nous vous fournirons des informations pour d'autres prestataires médicaux locaux.



Eastport Health Care Inc.
Patient Registration Form
Our Specialty is YOU!

Current Patient Information (Please Print)				
Last Name:	First Name:	Middle Name:	Preferred Name:	
Street Address	PO Box	City	State	Zip
Home Phone: Primary __Y __N	Cell Phone: Primary __Y __N	Work Phone:	Email: (see below)	
Would you like to sign up for our patient portal? ____ Yes (please list email above) ____ Declined				
Date of Birth:	Marital Status:	Social Security #:	Gender:	Primary Caregiver:
Guarantor Name:		Guarantor Address:		Guarantor Phone:
Relationship to Patient:		Social Security #:	Date of Birth:	
Emergency Contact:	Relationship to Patient:	Home Phone:	Cell Phone:	
Medical Insurance Information				
Primary Medical Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
Secondary Medical Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
Dental Insurance Information				
Primary Dental Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
Secondary Dental Insurance Name	Policy #	Group#	Employer Name	
Policy Holder Name/Address (if other than self)		Policy Holder DOB	Relationship to Policy Holder	
Notice of Privacy Practice, Consent, and Assignment of Benefits		Payment and No Show Policy		
<p>I hereby assign my insurance benefits to be paid directly to the Provider. I authorize the Provider to release any medical/dental information required to process claims. I authorize my Provider's office to contact me by telephone to remind me of my appointment. I acknowledge that I have reviewed the Consent for Medical and Dental Treatment, the Notice of Privacy Practices, and Patient Centered partnership of Care patient rights forms. By signing below I acknowledge that I have read and agree to the statements listed above and any questions or concerns I have were addressed.</p> <p>Patient/Parent/Guarantor/Authorized Representative Signature:</p>		<p>Quality Care for our patients is our priority. EHC has developed a Payment Policy and No Show Policy to assist you in understanding your financial obligations and the impact on our practice when a patient "no-shows". By signing below, I acknowledge that I have reviewed, understand, and agree to adhere to the policies.</p> <p>Patient/Parent/Guarantor/Authorized Rep. Signature:</p>		
Date:		Date:		



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Eastport Health Care, Inc. is a Federally Qualified Health Center funded by the Bureau of Primary Health Care. As a requirement for funding, we are responsible for collecting the following data on all of our patients. If you choose not to share this data, please indicate by checking "declined".

Annual income: \$_____ per year per month every two weeks weekly Declined

Number of Household Members: _____ Declined

Agricultural Worker: Migrant Seasonal No Declined

School-Based Health Center Patient: Yes No Declined

Name of School: _____

Homeless Status: Yes No Declined Veteran Status: Yes No Declined

Public Housing Patient: Yes No Declined Preferred Language: English Other Declined

Race: African American American Indian Alaskan Native Asian Other Race White Declined

Ethnicity: Central American Cuban Dominican Hispanic or Latino/Spanish Latin American/Latin, Latino
 Mexican Non-Hispanic or Latino Puerto Rican South American Spaniard Declined

Sex: Male Female Chose not to disclose

Patient Name: _____

Signature: _____
 Patient/Parent/Guarantor/Authorized Representative

Date: _____

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CONSENT FOR TREATMENT AT EASTPORT HEALTH CARE

1. I am aware that the practice of medicine/dentistry is not an exact science and that EHC offers no guarantee concerning any treatments or examinations that I may have here.
2. I understand EHC and its employees may use the information contained in my record for proper medical/dental purposes, and for clinical improvement audits.
3. I authorize the medical/dental staff at EHC to conduct any diagnostic examinations, test and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for a particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
4. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

SIGNATURE: By signing below I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

Patient/Authorized Representative* Signature

Date

*If signed by an Authorized Representative

Printed name of Authorized Representative

Source of Authority (e.g., guardian, Power of attorney)



Eastport
Health Care

Eastport Health Care Inc.-

Behavioral Health Departments - Medical Records

30 Boynton Street - Eastport, Maine 04631

160 Dublin Street - Machias, Maine 04654

Tel#(207)853-0185 or 207-255- 3400 Fax (207)853-4028

Patient Name:

Patient Former Name or Alias:

Patient Address:

Date of Birth:

Patient Phone:

Authorization to Release Health Information

I give my permission for EHC (Eastport Health Care) and its employees to:

Get My Medical Information indicated below **FROM** **OR** **Send My Medical Information** indicated below **TO**

Name of Person or Organization: _____

City/State/Zip: _____

Phone: _____ Fax: _____

To be Mailed Faxed Emailed (if requesting secure electronic delivery) _____

Email Address

Dates of Care or Dates of Records

All Records _____

(Note: check "All Records" ONLY if all medical records are needed. Sensitive Medical Information is not included unless selected below.)

OR I wish to release **Only those items selected below:**

Clinic Records _____

Immunization Records _____

Lab Reports _____

Hospital Records _____

Radiology Reports _____

Summary Records _____

Other Records _____

Sensitive Medical Information (Substance Abuse, Mental Health, HIV/AIDS): THIS SECTION MUST BE COMPLETED

I understand what may happen if I release the following sensitive information and have indicated which items I do wish to release and/or those I do not wish to release below. Consent to release these records may include all information unless I specify specific dates below.

I DO / **I DO NOT** wish to release HIV/AIDS records _____

I DO / **I DO NOT** wish to release Mental Health Treatment records _____

I DO / **I DO NOT** wish to release Substance Use Disorder Treatment records _____

 I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I authorize the release of the Sensitive Medical Information selected above without review UNLESS I initial here _____.

The purpose of the disclosure is (check where applicable):

Coordination of Medical Care Transfer of Medical Care Insurance Legal Disability School Entry Referral
 For Personal Use, please explain _____ Other, specify _____

Other Instructions: _____

Please use this space to indicate any special requests, information you do not wish disclosed, a different event or expiration for this Authorization, or any other instructions which may assist us with your request.

This Authorization is for a one-time disclosure OR multiple disclosures (Note: authorization for disclosure of certain mental health records cannot be continuing authorizations)

This Authorization expires: _____ Note: If left blank, this form will expire in ninety (90) days for one-time disclosures or in (1) year for multiple disclosures of health records. **Exception:** Six (6) months for children in residential and foster care.



Eastport Health Care Inc. - Behavioral Health Department
Medical Records
 Tel:(207) 853-0185 or 207-255-3400
 Fax (207) 853-4028

Patient Name:
Date of Birth:

This Authorization Form is voluntary and you may refuse to sign it. You may also cross out any words on this form that you do not agree with. Refusal to sign the form will not block your ability to receive health care services or payment for services; except that refusing to sign will mean you will not receive health services if those services are only to provide your Medical Information to someone else which requires a signed Authorization form. Refusal to sign this form may cause improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other negative outcomes. I understand that certain health information I authorize to be disclosed may be subject to redisclosure by the recipient and no longer protected.

You may have a copy of this form if you wish. In addition, you have the right to review the records before they are sent. You also have the right to receive a copy of the information requested in this form. Patients may receive a personal copy of these records at no charge, while a fee will be assessed for third party requests. The current prices are available where you receive care or by calling Medical Records at (207) 853-6001. The requested information will be sent within thirty (30) days of when you submit a completed form and pay any required fee.

- If you ask that copies of the requested information be sent by mail, EHC may send that information on a compact disc unless you have given other instructions.
- If you ask for e-mail copies of the information, you must provide a valid e-mail address. Your records will be given as Adobe PDF files via EHC's secure messaging method. EHC will send an email to the email address you provide with instructions on how to access your medical information.

You can revoke this authorization at any time by sending a written request to the person or entity that is sending us the records, or to us if we are the ones releasing your records to an outside entity or person. If you cancel this Authorization, it will not stop or change any action already taken by EHC or any other entity named in this release that was taken in reliance on this authorization and prior to receiving your notice to cancel. Canceling this form can cause denial of health benefits or other insurance coverage benefits.

I have read this Authorization form and I understand it. By signing below, I give my permission for EHC to release the Medical Information as described in this form and I release EHC, its employees, directors, officers and medical staff, from legal responsibility or liability for the release of the Medical Information.

Signed: _____ Date: _____
(Patient or Representative)

Print Name: _____

If not signed by the Patient, please indicate the authority to act for the patient: Parent Guardian Power of Attorney
[Please attached proof of authority if signing as a guardian or under a power of attorney.]

FOR OFFICE USE ONLY

Notice to Recipient of Prohibition on Redisclosure

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice Regarding Sensitive Medical Information

For persons/organizations receiving mental health information or HIV provided by EHC: This information has been disclosed to you from records protected by State confidentiality laws (22 M.R.S.A. § 1711-C(6)(A)(2) and/or 5 M.R.S.A. § 19201 *et seq.*). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

EHC Use Only: Received By: _____ Location: _____ Date: _____
 Rev. 4/27/2018



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EHC Patient Portal Access and Consent

Eastport Health Care is pleased to offer established patients access to our online Patient Portal managed by Athenahealth, our electronic health record platform. The patient portal is a secure way to access your health information, contact your provider with questions, request refills, view appointments, view or pay your EHC bill and much more! Please read and sign below to request access or give permission to a family member/caretaker to access.

Important: By signing below, you understand that your patient portal contains personal health information including, but not limited to: diagnosis information, medication lists, allergy lists, past medical history information, visit summaries, mental health information, billing information, and appointment information. Eastport Health Care is not responsible for the misuse, unauthorized disclosure, or other use of information obtained by yourself or person you have given permission to through the patient portal. You are responsible for the creation and privacy of your portal password. Minor patients under the age of 13 do not have the ability to create a patient portal account. If requested, it will be created for the use of parents/legal guardians. Patients 18 and over must provide written permission for family members, caretakers, or others to have access to their patient portal. Permission may be revoked by the patient at any time by contacting Eastport Health Care.

Our patient portal may be accessed at: <https://8309.portal.athenahealth.com> or through the patient portal log-in link on our webpage: www.eastporthealth.org.

Patients Name: _____ Date of Birth: _____

Yes, please sign me up for the portal!

Email address: _____

I am the parent/legal guardian of the minor child above and wish to have access to their patient portal.

Parent/Guardian Name: _____

Email address: _____

I authorize access of my patient portal to:

Name: _____ Relationship: _____

Email address: _____

Signature: _____ Date: _____

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Authorization for Portal Communication

You may be contacted via text, email, or automated phone call for appointment reminders, health reminders, notification of a new bill, a new message from your provider, etc. Please use the spaces below to authorize consent to each of the three methods of contact.

Consent to text: ____ Yes ____ No

Consent to email: ____ Yes ____ No

Consent to call: ____ Yes ____ No

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Adult Medical Health History Form

*This form will help your clinician better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. **Please provide your best guess when a date is requested.***

Name: _____ Date of Birth: _____ Today's Date: _____
 Preferred Provider: _____ Preferred Pharmacy: _____

MEDICATIONS (Prescription and **non-prescription medicines**, vitamins, home remedies, birth control pills, herbs, oxygen, CPAP)

Medication and Dose	Instructions	Medication and Dose	Instructions

ALLERGIES (Medicines, Seasonal, Environmental, Foods)

Allergy	Reaction	Allergy	Reaction

PERSONAL MEDICAL HISTORY

Please make a check mark next to any medical problem you have ever had and list the date of diagnosis.

Condition	Yes	Condition	Yes
Heart Attack	<input type="checkbox"/>	Depression	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Suicide Attempt	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>
Bleeding/Clotting Disorder	<input type="checkbox"/>	Other*	<input type="checkbox"/>
Thyroid Problem, <i>please specify type</i>	<input type="checkbox"/>	Cancer, <i>please specify type</i>	<input type="checkbox"/>

*Other problems, *please specify* _____

If you have ever had a blood transfusion, please specify date(s) _____

Would a blood transfusion be acceptable in an emergency? ___ No ___ Yes

Do you have any religious or spiritual beliefs? ___ No ___ Yes

Do you have any advanced health care directives? ___ No ___ Yes

Last Dental Exam? _____ Last Eye Exam? _____ Last Podiatry Exam? _____

Surgical History	Date

Adult Medical Health History Form

WOMEN'S GYNECOLOGIC HISTORY

pregnancies: ____ # deliveries: ____ # miscarriages: ____ # abortions: ____ Age at first childbirth: ____
1st day, most recent period: ____ Age at 1st period: ____ Frequency of periods: ____
Length of each period: ____
Do you have any concerns about your periods? ___ No ___ Yes: _____
Ever had an abnormal PAP? ___ No ___ Yes: results _____
Do you have any concerns about menopause? ___ No ___ Yes: _____

SEXUALITY

Sexually Active: ____ Yes ____ No ____ Not currently
Current sex partner(s) is/are: ___ male ___ female
Birth Control method: _____ None needed
If sexually active, do you practice safe sex (use condoms)? ____ NA ____ No ____ Yes
Have you ever had any sexually transmitted diseases (STDs)? ____ No ____ Yes
If yes, please specify: _____ date _____
Are you interested in being screened for sexually transmitted diseases? ____ No ____ Yes
Ever been exposed to HIV/AIDS? ____ No ____ Yes
Have you been tested for HIV? ____ No ____ Yes: results _____
Would you like to be tested for HIV? ____ No ____ Yes
Other concerns? _____

SAFETY

Do you have a gun in your home? ____ No ____ Yes
Do you have a smoke detector in your home? ____ No ____ Yes
Do use seatbelts consistently? ____ No ____ Yes
Do you use sunscreen regularly? ____ No ____ Yes
Is violence at home a concern for you? ____ No ____ Yes
Do you feel safe in your current relationship? ____ N/A ____ No ____ Yes
Other concerns? _____

EMOTIONS

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
____ No ____ Yes
During the past month, have you often been bothered by little interest or pleasure in doing things?
____ No ____ Yes

HEALTH MAINTENANCE

Please enter the date of your most recent immunizations and tests.

Flu _____ Pneumonia _____ Shingles _____ Tetanus _____ HPV _____
Hepatitis A _____ Hepatitis B _____ Measles _____ Mumps _____ Rubella _____
MMR _____ Varicella (chicken pox) _____ PPD _____
PAP _____ Mammogram _____ Bone Density study _____ Colonoscopy _____ EKG _____

Adult Medical Health History Form

REVIEW OF SYSTEMS

Please make a check mark next to any symptoms you have had in the **last couple of days**:

Constitutional		Respiratory	
Unintended Weight Loss		Cough	
Unintended Weight Gain		Shortness of breath or difficulty breathing	
Poor Appetite		Wheezing	
Fever		Coughing up sputum	
Chills		Coughing up blood	
No Energy		Chest tightness	
Eyes		Gastrointestinal	
Pain		Difficulty swallowing	
Blurry vision		Abdominal pain	
Double Vision		Heartburn	
Redness		Nausea	
Itchiness		Vomiting	
Swelling		Diarrhea	
Discharge		Blood in stool	
Ears, Nose, Throat		Mucus in stool	
Ear Pain		Change in bowel habits	
Discharge		Loss of bowel control	
Hearing Loss		Genitourinary	
Ringing in the ears		Discharge	
Sinus Pressure		Blood in urine	
Drooling		Pain with urination	
Facial Swelling		Increased frequency or urgency	
Sore Throat		Urinary loss of control	
Mouth Lesions		Flank pain	
Dental Pain		Testicular pain or swelling	
Swollen Glands		Redness	
Cardiovascular		Itchiness	
Swelling		Masses/lumps	
Chest Pain		Musculoskeletal	
Shortness of breath with activity		Soft tissue swelling	
Heart Palpitations (heart racing or fluttering)		Muscle pain	
Breasts		Moves arms and legs well	
Lumps		Localized joint pain	
Tenderness		Previous injuries	
Discharge		Spine pain	
		Pain radiating down arms	
		Pain radiating down legs	
		Weakness in arms	
		Weakness in legs	

Adult Medical Health History Form

Skin		Female Health	
Pain		Irregular Menses	
Itching		Non-menstrual Bleeding	
Dryness/Flaking		Menopausal Symptoms	
Redness		Hot Flashes	
Rash/Hives		Night Sweats	
Growths/Lumps		Dry Vaginal Mucosa	
Swelling		Change in Libido (sex drive)	
Bruising		Orgasmic Dysfunction	
Insect Bites		Difficult or Painful Intercourse	
Lesions		Vaginal Tightening	
Neuro		Male Health	
Numbness		Change in Libido	
Weakness		Difficulty with Intercourse	
Tingling		Impotence	
Burning		Allergic/Immunologic	
Shooting Pain		Seasonal Allergies	
Headache		Sneezing	
Dizziness		Runny Nose	
Trouble finding words or forgetting words		Food Allergy	
Speech Difficulties		Contact Dermatitis (allergic skin rash)	
Poor Coordination			
Loss of Consciousness			
Arm or hand weakness			
Difficulty Emptying Bladder			
Change in Bowel Habits			
Psychiatric			
Decreased Functioning Ability			
Depression			
Anxiety			
Insomnia			
Stress			
Loss of Interest			

Please feel free to make any additional comments for any symptoms you are experiencing or any concerns you may have and would like to discuss at your initial appointment:
