Choosing Health
Northeastern Vermont Regional Hospital

Dear Patient,

Thank you for your interest in Kingdom Internal Medicine for your health care needs!

As a new patient requesting an appointment with one of our providers, here are a few things to complete:

[ ] New Patient Registration Form

[ ] Protected Health Information Release Request

(Fill this out with your last provider's information, so we can request your records. This is very important! Please call the office if you need help).

[ ] Health Review Form

Please complete each form and return to the staff at Kingdom Internal Medicine in person, by mail, or by fax at 802-745-1188 prior to your New Patient Appointment

Once we have received the completed forms, we will request your previous medical records. It is necessary for our office to obtain your medical records, prior to your new patient visit, so that our providers can give you the best care. It can typically take up to 30 days to receive your records from your previous provider. If you have any questions, or need assistance with completing these forms, then please call our office.

We can be reached by phone; **(802) 748-7500** or drop by the office;

714 Breezy Hill Road, St. Johnsbury Vermont.

We are always happy to help!

Sincerely,

The Kingdom Internal Medicine Staff & Providers;

Irene Krechetoff, DO, Thomas Myrter, DO,

Joyce Vitale, APRN, and Jessica MacLeod, APRN

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Some important things to know about Kingdom Internal Medicine:

Our staff and providers are dedicated to our patients. Our goal is to provide you with high quality, convenient care that focuses on your personal health and wellness goals.

Same Day Appointments: Each provider has a reserved number of appointments, dedicated to same day requests, which open at the start of each day. If you have a medical problem you believe requires same day attention, then we encourage you to call as early as possible as the appointments are first-come, first-served and fill quickly.

Cancellation of Appointments: We ask that you contact the office at least 24 hours in advance if you need to cancel your appointment. When you fail to cancel a visit, you prevent that time being given to another patient who needs care. We understand that circumstances may arise in which you are unable to give at least a 24-hour notice, but please contact the office as soon as you can.

No Show Policy: When you have a scheduled appointment that you do not attend, this is considered a "no-show". As a new patient, it is important to attend your New Patient Appointment. If you no-show 2 New Patient Appointments, then we will no longer schedule you an appointment to establish care with us, and you will need to seek care elsewhere. Once established with the practice, 3 failures to attend a scheduled visit, without prior notification, will result in dismissal from the practice. A copy of our No-Show Policy will be provided to you.

Prescription Refills: We ask that you contact the office regarding medication refills at least **72 hours in advance** to allow sufficient time for your provider to receive and respond to your request before you run out of your medication. Typically, for maintenance medication your provider will provide refills to last until your next scheduled appointment. If you are out of refills, this may indicate that you are due for an appointment with your provider.

Telephone Calls: Should you have a question, or feel as though you need to speak with your provider, you will first be given to our triage nurse. Once the nurse has had the chance to consult with a provider, your call will be returned. Many issues cannot be addressed over the phone, so you may be asked to schedule an office visit with a provider to give you the appropriate care.

We thank you for allowing us to participate in your healthcare and hope that the above information will assist you in obtaining prompt and convenient medical care.

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Kingdom Internal Medicine - New Patient Registration Form

Demographic Information:

First Name: _____ **Middle Initial**: _____ **Last Name**: _____

(Please Select) [ ] Maiden [ ] Former [ ] Preferred Name: _____

Date of Birth: _____/_____/_____ **SSN#**: _____-_____-_____ **Sex**: (Please Select) [ ] Male [ ] Female

Mailing Address: _____**City**: _____ **State**: _____ **Zip**: _____

Physical Address (If different from above): _____ **City**: _____ **State**: _____ **Zip**: _____

Phone Number: Home (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Primary Phone Number (Please Select): [ ] Home [ ] Cell [ ] Work

Email Address: _____

Marital Status (Please Select): [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Civil Union [ ] Separated [ ] Life Partner

Race (Please Select): [ ] Asian [ ] African American [ ] American Indian [ ] Caucasian (White) [ ] Other [ ] Decline to Provide

Ethnicity (Please Select): [ ] Hispanic [ ] Not Hispanic [ ] Decline to Provide

Preferred Language: _____ **Religion**: _____

Veteran (Please Select): [ ] Yes [ ] No **Do you have an Advance Directive?** (Please Select): [ ] Yes [ ] No

Do you have health insurance? [ ] Yes [ ] No

If yes, Insurance Carrier: _____

Policy or ID Number: _____

Continued on back →

Employment Information:

Place of Employment: _____ **Occupation**: _____

Address: _____**City**: _____ **State**: _____ **Zip**: _____

Status (Please Select): [ ] Unemployed [ ] FT [ ] PT [ ] Retired **Work Phone Number**: (_____) _____-_____

Emergency Contact Information:

Emergency Contact #1

First Name: _____ **Last Name**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone Number (Please Select): [ ] Home [ ] Cell [ ] Work : (_____) _____-_____

Relationship to you: _____

Emergency Contact #2

First Name: _____ **Last Name**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone Number (Please Select): [ ] Home [ ] Cell [ ] Work : (_____) _____-_____

Relationship to you: _____

Other: [For Clinic Use]

Choice of Primary Care Provider, if available: _____

How did you hear about Kingdom Internal Medicine? (Please Select):

[ ] Relative [ ] Friend [ ] Website [ ] Organization: _____ [ ] Other: _____

Patient Authorization

I hereby give authorization to Irene Krechetoff, DO, Thomas Myrter, DO, Joyce Vitale, APRN, Jessica MacLeod, APRN, and staff to administer medical treatment, local anesthetics (as needed) and to perform any diagnostic laboratory studies that may be deemed necessary.

_____ _____

Patient Signature Date

Kingdom Internal Medicine
714 Breezy Hill Road
St Johnsbury VT 05819
Phone 802-748-7500
Fax 802-745-1188

MRN: _____
Patient Name: _____
Date of Birth: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Authorization to Disclose Protected Health Information

1. **I AUTHORIZE NORTHEASTERN VERMONT REGIONAL HOSPITAL AND ITS AGENTS TO RELEASE THE REQUESTED PROTECTED HEALTH INFORMATION TO OR RECEIVE PROTECTED HEALTH INFORMATION FROM THE PARTIES LISTED ON PAGE 2 OF THIS DOCUMENT.**

2. By signing this form I am certifying that I am the patient or, a legally authorized representative (Health Care Agent Legal Guardian, Executor, etc.

3. I understand that if the medical record is complete and contains final copies of all reports, documentation, and appropriate signatures, my request for information will be submitted for processing.

I understand that:

- The information to be released may include information related to Hepatitis, sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health services, and treatment of alcohol or drug abuse. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance use disorder records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.
- I may be charged a fee for copies in accordance with the state and federal law.
- I have a right to revoke this authorization at any time by submitting a written request to the Department or Office where I originally submitted it. My revocation will not apply to the information that has already been released in response to this authorization.
- Information used or disclosed pursuant to this authorization may be re-disclosed by recipient and may no longer be protected under federal and state law.
- Signing this form is voluntary. I do not need to sign this form to receive health services at Northeastern Vermont Regional Hospital.

Expiration of Authorization:

I understand that this authorization will expire on _____ (insert expiration date). If I do not specify an expiration date, this authorization will expire 1 year from the date I signed the authorization.

_____ _____

Signature of Patient/Legal Representative **Date**

_____ _____

Print Name **Relationship to Patient**
(If signed by Legal Representative)

Kingdom Internal Medicine
714 Breezy Hill Road
St Johnsbury VT 05819
Phone 802-748-7500
Fax 802-745-1188

MRN: _____
Patient Name: _____
Date of Birth: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Address: _____

City: _____ State:_____ Zip Code:_____ Phone #_____

PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent to, or information you would like sent from.

☐ Information to: ☐ Receive information from:

- ☐ Pick up
- ☐ Send out

Name: _____
Address: _____
Telephone Number: _____
Fax Number: _____
Date of Request: _____ Date Needed: _____

Purpose for Release:

☐Current Treatment ☐ Personal Records ☐ Insurance ☐ Worker's Compensation
☐Attorney/Legal Claim ☐ Provider Transfer ☐ Disability ☐Other (please specify): _____

INFORMATION TO BE RELEASED (please check all that apply and specify dates):

☐Hospital Abstract (e.g. History & Physical, Consult Notes, Progress Notes, All Clinical Charts,etc.)
☐Discharge Summary
☐Operative Report, Test Results, Discharge Summary)
☐Lab Reports
☐Operative Reports
☐Pathology Reports
☐Immunizations
☐Physical, Occupational, Speech Therapy Notes
☐Other (please specify): _____
☐Clinic Visit Notes
☐Radiology Reports
☐Radiology Images
☐ED Report
☐Medication List

Dates of Care to be Released: _____ to _____
Information Released/Reviewed by: _____ Date: _____

For office use only.

Identification verified by: _____ Date: _____

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Health Review Questionnaires

Patient Name: _____ DOB: _____ Date: _____

Preferred Name: _____ Preferred Pronouns: _____

Patient Health Questionnaire-2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. **Little interest or pleasure in doing things** (circle one) Not at all Several days More than half the days Nearly every day

2. **Feeling down, depressed, or hopeless** Not at all Several days More than half the days Nearly every day

Vermont SBIRT Screening

Smoking/Tobacco Use Status: (circle one)
Never Current Every Day Current-Occasional Former Use Current, status unknown Unknown
Type: _____
How many years used: _____
Smokeless Tobacco User: Chewing tobacco Snuff Snus Dissolvable tobacco Other: _____

Passive Smoke Exposure: Yes or No

Quit Status: Considering quitting Not considering quitting Quit date established Have quit before

How often have you used marijuana in the past year (including smoking, vaping, dabbing, edibles)?

Never Monthly or less Several days per month Weekly Several days per week Daily

How often in the past year have you used prescription meds that were not prescribed to you?
Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times per week
How often in the past year have you taken your own prescription meds MORE than the way it was prescribed OR for different reasons than its intended purpose?

Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times per week

How often in the past year have you used other drugs (i.e. heroin, cocaine, salvia, inhalants, etc.)?
Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times per week

Audit-C Alcohol Screening

How often do you have a drink containing alcohol? (circle one)
Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times per week

How many drinks containing alcohol do you have on a typical day?
1 – 2 3 – 4 5 – 6 7 – 9 10 or more Decline to answer

How often do you have 6 or more drinks on 1 occasion?
Never Less than monthly Monthly Weekly Daily or almost daily Decline to answer

AHC Health-Related Social Need Screening

What is your living situation today? (circle one)
I do not have steady housing I have housing but am worried about losing it I have steady housing

In the place you live, do you have problems with any of the following: (circle all that apply)
Pests such as bugs, ants or rodents Mold Lead paint or pipes Lack of heat Oven/Stove not working
Smoke detectors missing/not working Water leaks None of the above

Within the past 12 months, you worried whether your food would run out before you got money to buy more.
Often true Sometimes true Never true Don't know Decline to answer

Within the past 12 months, the food you bought just didn't last, and you didn't have money to get more.
Often true Sometimes true Never true Don't know Decline to answer

In the past year, has a lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Yes No

In the past year, has the electric, gas, oil or water company threatened to shut off services in your home?
Yes No Already shut off

How often does anyone, including family and friends, physically hurt you?
Never Rarely Sometimes Fairly Often Frequently

How often does anyone, including family and friends, insult or talk down to you?
Never Rarely Sometimes Fairly Often Frequently

How often does anyone, including family and friends, threaten you with harm?
Never Rarely Sometimes Fairly Often Frequently

How often does anyone, including family and friends, scream or curse at you?
Never Rarely Sometimes Fairly Often Frequently

Medications:

Please list all of the **medication you are currently taking**, including non-prescription and herbal medications;

Name of Medication	Amount (Dose)	Date Started	Prescribing Provider	Reason for Taking

Are you allergic to any medications? Please list: _____

Surgical History:

Surgery	Date	Location and/or Provider

Patient Name: Date of Birth: Date:

Are you Adopted? Yes or No **Do you have a caregiver?** Yes or No **Were you in foster care?** Yes or No

Who lives in your household? Spouse Significant other Family Children Friend(s) Other_____

What type of housing do you live in? Apartment House Condo Assisted living facility Nursing home Homeless

How many children do you have? _____ **How many grandchildren do you have? ____**

Communication Needs? None Deaf Hard of hearing Sign language Blind Corrective lenses Cannot read Language barrier

Education Level? Master's Degree(or higher) Bachelor's Degree Associate's Degree Vocational High School Middle School Elementary

Do you need help understanding health information? Never Rarely Often Always

Current Occupation:_____

Do you have pets? Yes or No What type? (Cat, dog, horse etc.)_____How many?_____

Are you sexually active? Yes or No

Do you think of yourself as Straight/heterosexual Lesbian/gay/homosexual Bisexual

What gender do you currently identify as? Male Female Trans female to male Trans male to female Decline to answer

What is your relationship status? (Circle One)

Married Living with partner Widowed Divorced Separated Never married Decline to answer

How often do you talk on the phone with friends or family? (Circle one)

Never Once per week Twice per week Three or more times per week Decline to answer

How often do you get together with friends or family? (Circle one)

Never Once per week Twice per week Three or more times per week Decline to answer

Do you belong to any clubs or organized social groups? Yes or No Decline to answer (Circle one)

What type of REGULAR EXERCISE do you participate in? (Weights, Running etc.)_____

How many minutes per day? Less than 15 15-30 30-45 45-60 60-90 More than 90

How many days per week? 1-2 3-4 5-6 Daily

FEMALES:
Would you like to become pregnant in the next year?

Yes

Ok, either way

Unsure

No

My current faith or religion is: Jewish Mormon Baptist Islamic Buddhism Hinduism Jehovah's Witness Christian Other_____ None

Do you have any special ***medical*** faith needs? Yes or No

I wear a seatbelt:	**I wear a helmet:**	**I drive while intoxicated:**	**I ride with an intoxicated driver:**
Always Sometimes Never	Always Sometimes Never	Yes or No	Yes or No

Family History:

Please write down your relative(s) that have/had the condition. List any additional conditions, if not listed:

Problem/Condition	**Relative (please indicate *maternal* for mother's side and *paternal* for father's side: for example, maternal grandmother)**
Alcohol or Drug Problem	
Anxiety	
Asthma	
Cancer **(Please include type)**	
Depression	
Diabetes	
Heart Disease	
Hypertension (High Blood Pressure)	
Other:	

Review of Symptoms:

Circle any conditions/symptoms that currently apply.

Head:	**Digestive:**	**Respiratory:**	**Musculoskeletal:**	**Cardiovascular:**	**Urinary:**
Dizziness	Nausea/Vomiting	Wheezing	Joint Stiffness	Pain/Pressure in Chest	Frequent Urination
Seizures	Trouble Swallowing	Cough	Joint Swelling	Irregular/Fast Heartbeat	Urinary Burning
Numbness/Tingling	Diarrhea/Constipation	Shortness of Breath	Frequent/Severe Back Pain	Swelling of Feet/Legs	Loss of Urine Control
Fainting Spells	Blood in Stools	Coughing up Blood		Calf Pain when Walking	Trouble Getting Urine Started
Persistent Eye Pain	Black Stools	Snoring		Murmur	
Vision Changes	Abdominal Pain				
Headaches	Vomiting Blood				
	Heartburn				
Feelings:	**Situations:**	**Other:**	**Men:**	**Women:**	**Additional Not Listed:**
Sad/Depressed/Hopeless	Marital Problems	Frequent Thirst	Drainage from Penis	Irregular/Heavy Periods	_____
Wish to End it All	Financial Problems	Skin Lesions the Won't Heal	Sores on Penis	Vaginal Itch/Discharge	_____
Tense/Worried	Sexual Problems	Frequent Infections	Swelling in Groin	Bleeding After Menopause	_____
Lonely	Pressure at Work	Constant Fatigue	Pain with Intercourse	Lump in Breast	_____
Cry A Lot		Unexplained Fever	Trouble with Erection	Inability to Get Pregnant	_____
Aggressive		Itchy/Dry Skin or Scalp	Enlarging/Lumpy Testicle	Hot Flashes	_____
Little Interest/Pleasure in Doing Things		Difficultly Sleeping		Pain with Intercourse	_____
					_____