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; Xavier Giddings, APRN, Thomas Myrter, DO, Joyce Vitale, APRN, Jessica MacLeod, APRN, and Tina Heck APRN.

Choosing Health
Northeastern Vermont Regional Hospital

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.

NORTHEASTERN VERMONT REGIONAL HOSPITAL

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:** ________

Number: Home (_____) ______- ______ Cell (_____) _____- _____ _ Work (_____) _____- ________

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

Email Address: ____

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

[ ] Legally Separated [ ] Life Partner [ ] Unknown

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

[ ] Decline to Provide [ ] Native Hawaiian/Pacific Island

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

Preferred Language: ___________________________ **Interpreter Needed?** __________

Religion: __________________

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

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: ____________ ______________________

Choice of Primary Care Provider, if available: ____ ____ _____

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

If yes, Insurance Carrier: __ ______________ _________ ____________ ______________ ____________

Policy or ID Number: __ ________________________ _____________

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:** ________________

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

3. **Trouble falling or staying asleep, or sleeping too much**
   Not at all   Several days   More than half the days   Nearly every day

4. **Feeling tired or having little energy**
   Not at all   Several days   More than half the days   Nearly every day

5. **Poor appetite or overeating**
   Not at all   Several days   More than half the days   Nearly every day

6. **Feeling bad about yourself – or that you are a failure or have let yourself and your family down**
   Not at all   Several days   More than half the days   Nearly every day

7. **Trouble concentrating on things, such as reading the newspaper or watching television**
   Not at all   Several days   More than half the days   Nearly every day

8. **Moving or speaking so slowly that people could have noticed? – or the opposite – being so fidgety or restless that you have been moving around a lot more than usual**
   Not at all   Several days   More than half the days   Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Difficult   Somewhat   Very   Extremely

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 Decline to Answer

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

Social Determinants of Health

Do you worry about having a steady place to live?
Yes No Choose not to answer (circle one)
If yes: (circle one)
I do not have steady housing I have housing but am worried about losing it

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/Pipes
☐ Lack of heat	☐ Oven/Stove not working	☐ Smoke detectors missing/not working
☐ Carbon monoxide detectors missing/not working	☐ Water leaks	☐ Unsafe flooring/stairs
☐ Inadequate lighting	☐ Other	☐ None of the above

Within the past 12 months have you had to go without electric, gas, oil or water in your house.
Yes No Decline to answer

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

Has lack of reliable transportation kept you from medical appointments, or from doing things needed for daily living?
Yes No Decline to answer

Has anyone in your life made you feel unsafe or unsupported?
Yes No Decline to answer

If Yes answer following:

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

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
Very hard Somewhat hard Not at all

Do you want help finding or keeping a job?
Yes, help finding work Yes, Help keeping work I do not need or want help

If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc. Do you get the help you need?
I don't need any help. I get all the help I need. I could use a little more help. I need a lot more help.

How often do you feel lonely or isolated from those around you?
Never Rarely Sometimes Often Always

Do you speak a language other than English at home?
Yes No

Would you like assistance with any of the above questions?
Yes No

Medications:

Please list all the **medications 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) None Other_______________

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

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) College 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 Don't Know Decline to answer Other_______________

What gender do you currently identify as? Male Female Trans female to male Trans male to female Neither Exclusively Male nor Female Other__________ 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? (Circle one) Yes or No Decline to answer

How often do you attend Church or Religious services? (Circle one) 1-3 Times per year 4 or more times per year Decline to Answer None

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

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: Always Sometimes Never	**I wear a helmet:** Always Sometimes Never	**I drive while intoxicated or ride with an intoxicated driver** 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	______________
					______________

MyPortal

Choosing Health
NORTHEASTERN VERMONT REGIONAL HOSPITAL

NVRH Patient Portal

Access your healthcare information anytime from anywhere using a smartphone or computer!

A few of the Portal capabilities include:

- Send a message to your provider
- Request a refill for your prescription
- Pay your bill
- View scheduled appointments as well as visit history of past appointments
- View diagnostic imaging and laboratory results
- Easily print out a list of medications, allergies, immunizations or conditions
- Review and print letters written to you by your provider

For more information visit nvrh.c

MYPORTAL.NVRH.ORG

Manage Your Health Care

Your Online Health Record

Click here to learn how to sign up.

NVRH Mobile App