Health Centers NOCHSI
Fulton • Mexico • Oswego • Parish • Phoenix • Pulaski

Administrative Offices at:
Northern Oswego County Health Services, Inc.
61 Delano Street, Pulaski, New York 13142-1400
(315) 298-6569 Fax (315) 298-7488 www.nochsi.org

Dear New Patient,

Thank you for choosing Northern Oswego County Health Services, Inc. (NOCHSI) Phoenix Health Center for your health care needs. You are scheduled to see _____on _____ at_____ the Phoenix Health Center. Please arrive to our office 15 minutes prior to your scheduled appointment to complete the necessary new patient paperwork.

To prepare for your upcoming appointment, it is critical that you complete the enclosed Request for Information form, so we can request your previous medical records from your past provider to assist us in providing you with continuity of care. This completed form is to be returned to our office ASAP to ensure enough time to secure your records.

New Patient Confirmation Policy:
Our office will call you 48 hours prior to your scheduled appointment time to confirm your appointment. If we are unable to confirm your appointment within 24 hours of your scheduled time, your appointment will be cancelled. Please note that if you miss two new patient appointments in our office, you will be discharged from the NOCHSI network.

Location:
Our office is located at 7 Bridge Street, Phoenix, New York 13135

Hours of Operation:
Monday and Wednesday7:30am-6:30pm
Tuesday, Thursday and Friday 7:30am-5:00pm

Contact Information:
Phone Number: 315.695.4700 Fax: 315.695.4706
*Please be sure to choose from the options listed on our main greeting for fastest service

Items Needed For your First Appointment in our office:

- Insurance Cards
- Photo ID (if you have one)
- Custody Paperwork
- Medication List including prescription bottles

About Us:
The Phoenix Health Center is one of six health centers within the NOCHSI primary care network, which also includes Fulton, Mexico, Oswego, Parish, and Pulaski Health Centers. In addition, we have six School Base Health

Centers located within the following school districts; Altmar Parish Williamstown (APW), Pulaski, and Sandy Creek and our newest location at the Mexico Middle School. NOCHSI is a designated Patient Centered Medical Home, which strives to provide our patients with comprehensive evidence based care, self-management support and coordination of care across various health care settings.

If you have any questions between now and your appointment or have any acute concerns that needs to be addressed, please call and we will help direct you to the appropriate staff member who can assist you.

We look forward to partnering with you to provide the best possible services to meet your health care needs. Welcome to the NOCHSI network!

Sincerely,

Northern Oswego County Health Services Inc. Staff

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Northern Oswego County Health Sevices, Inc
Patient Registration Form

Patient Information

Last Name:	First Name:	MI:	Suffix:
Social Security Number:			
Mailing Address:			
City:	State:	Zip Code:	
Date of Birth:	Gender: ( ) Male ( ) Female	Phone #: ( ) [ ] Home [ ] Other	E-Mail Address:
Please give us the names of other family members who come here for care:			

Responsible Party Information

[ ] Check here if same as patient and complete insurance section on the back, OR complete this section if other than patient.

Last Name:	First Name:	MI:	Suffix:
Social Security Number:	Date of Birth:	Gender: ( ) Male ( ) Female	
Provide address & phone only if they are different from the patient's:			
Mailing Address:			
City:	State:	Zip Code:	
Home Phone #: ( ) -	E-Mail Address:		

Additional Patient Information

Marital Status: [ ] Married [ ] Divorced [ ] Widowed [ ] Single [ ] Other	Employment Status: [ ] Full time [ ] Part time [ ] Retired [ ] Self employed [ ] Unemployed [ ] Active Military [ ] Retired Military
Student Status: [ ] Full time [ ] Part time [ ] N/A	Race: [ ] American Indian [ ] Asian Pacific [ ] Black, Non-Hispanic [ ] White, Non-Hispanic [ ] Hispanic [ ] Pacific Islander
Patient Relationship to Responsible Party: [ ] Self [ ] Child [ ] Spouse [ ] Other	Resident County:
Work Phone: ( )	Emergency Phone: ( ) Contact Name:

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Do you have insurance?

❑ YES Please provide insurance information below and give us your card so that we can make a copy for our records.	❑ NO Please ask us about: * Child Health Plus *Family Health Plus * Medicaid *Sliding Fee Scale

Primary Insurance Coverage

Carrier Name:				
Co-pay Amount: $	**Annual Deductible Amount:** $	**Insured Party:** ( ) Patient ( ) Responsible Party ( ) Other	**Insured ID #:**	**Group #:**
Primary Care Provider:				
Complete the remainder of this section ONLY if the Insured Party is "Other" than Patient or Responsible Party.				
Insured's Last Name:		**Insured's First Name:**	**Insured's Social Security #:**	
Gender of Insured: ( ) Male ( ) Female		**Insured's Date of Birth:**		

Secondary Insurance Coverage

Carrier Name:				
Co-pay Amount: $	**Annual Deductible Amount:** $	**Insured Party:** ( ) Patient ( ) Responsible Party ( ) Other	**Insured ID #:**	**Group #:**
Primary Care Provider:				
Complete the remainder of this section ONLY if the Insured Party is "Other" than Patient or Responsible Party.				
Insured's Last Name:		**Insured's First Name:**	**Insured's Social Security #:**	
Gender of Insured: ( ) Male ( ) Female		**Insured's Date of Birth:**		

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NORTHERN OSWEGO COUNTY HEALTH SERVICES, INC.
Phoenix Health Center, 7 Bridge Street, Phoenix, NY 13135

REQUEST FOR INFORMATION

PATIENT NAME:_____
Last First MI Maiden/Other Name

DATE OF BIRTH:_____ **SS#:**_____/____/_____

I hereby authorize NORTHERN OSWEGO COUNTY HEALTH SERVICES, INC. to obtain protected health information from my medical record as indicated below from:

MEDICAL PROVIDER / FACILITY: _____

ADDRESS:_____CITY:_____ STATE:_____ ZIP:_____

INFORMATION TO BE OBTAINED:

- ☐ History/Physical
- ☐ Progress notes
- ☐ Lab reports
- ☐ X-ray reports
- ☐ Other:_____

Dates

ALL Records

_____

_____

PURPOSE OF REQUEST:

- ☐ Changing physician
- ☐ Continuing care
- ☐ Legal / Insurance
- ☐ Other:_____

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line below: Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

- I understand that this authorization will expire **90 (ninety)** days after I have signed the form.
- I understand that I **may revoke** this authorization at any time by notifying the Northern Oswego County Health Services, Inc. in writing, and it will be effective on the date notified except to the extent action has already been taken upon it.
- Northern Oswego County Health Center, Inc. follows the NYS Public Health Law Section 18 (l)(e) for re-disclosure of protected health information.

Print Patient's Name:_____
If the patient is a minor, I have the authority to sign this request for information [ ] Yes [ ] No

_____ _____ _____
Signature of Patient/Parent/Legal Representative Date Relationship to Patient

_____ _____
Witness Signature Date

PLEASE: MAIL RECORDS _____

FAX RECORDS *TO:* *(315)695-4706*

Call with any questions to (315)695-4700 x 7006

FOR OFFICE USE ONLY
Identification shown:_____ To:_____
Request sent: _____ By:_____ Logged:_____

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Northern Oswego County Health Services, Inc.
Child Health History Form

Name:_____ Date:_____

DOB: _____ Sex: M F

MEDICAL HISTORY:

Birth Wt.:_____ Length:_____ Place of Birth: _____

Does the child have any serious medical problems? If yes please list:	
FAMILY HISTORY: Any family history of serious illnesses such as diabetes, high blood pressure, heart disease, cancer, or tuberculosis:	
HOSPITALIZATIONS/SURGERY:	**NONE:**
DATE:	CONDITION/SURGERY:

SOCIAL HISTORY:

Number of Adults at Home: _____ Number of Children at Home:_____

Any Smokers Living in the Home? _____

Current School: _____

Does the child have records at an additional Physician/Pediatrician's office? Yes / No

If yes please list name and address: _____

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61 Delano Street, Pulaski, NY 13142

Form to Designate Representative for Health Care Needs Rev. 04.17.2014

Is there anyone involved in your health care or payment for your health care with whom we may share your medical information?

I, _____Date of Birth_____designate

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone number

To act as my representative in the following situations:

_____Test results

_____Medication questions/refills

_____ Schedule/Cancel Appointments

_____Other (please specify)

The individual above has permission to pick up the following:
_____Medication

_____Prescriptions

_____Medical Records

_____Other (please specify)

Staff only please check box and initial when entered in chart.
☐ _____

Signed _____Date_____

*Expiration Date _____

Witness Signature _____

This form may be revoked at any time.

Serving the community since 1969
NOCHSI is an Equal Opportunity Provider and Employer
Complaints of discrimination should be sent to: USDA Director Office of Civil Rights, 1400 Independence Ave., S.W., Washington, DC 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD)