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) Pulaski Health Center for your health care needs. You are scheduled to see _____on _____ at_____the Pulaski 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 61 Delano Street, Pulaski New York 13142

Hours of Operation:
Monday, Wednesday and Thursday 7:30am-9:00pm
Tuesday 7:00am-9:00pm
Friday 8:00am-9:00pm
Saturday 9:00am-1:00pm
Sunday 12:00pm-4:00pm
Walk-In Hours for acute care~ Monday through Friday 8:00-10:45am and 1:00-3:45pm

Contact Information:
Phone Number: 315.298.6564 Fax: 315.298.3968
*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 Pulaski Health Center is one of six health centers within the NOCHSI primary care network, which also includes Fulton, Mexico, Oswego, Parish, and Phoenix 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.
Pulaski Health Center, 61 Delano Street, Pulaski NY 13142

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: **Last 2yrs of available 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)298-3968*

Call with any questions to (315)298-6564 x2303

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

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This is a 2 sided form – Please complete both sides

Northern Oswego County Health Services, Inc.

Adult Health History Form

Name:_____ Date:_____

DOB: _____ Sex: M F

MEDICAL PROBLEMS: Do you have, or have you had any of the following medical problems? Circle Y for Yes or N for No, if yes please explain below.

Y	N	High Blood Pressure	Y	N	Kidney Disease
Y	N	Heart Disease	Y	N	Liver Disease
Y	N	Diabetes	Y	N	Cancer of any type
Y	N	Thyroid Problems	Y	N	Neurological Disease
Y	N	High Cholesterol	Y	N	Orthopedic Problems
Y	N	Chronic Lung Disease	Y	N	Arthritis
Y	N	Stomach Disorders	Y	N	Infectious Disease/Hepatitis/HIV

List any other serious illnesses/or explain Yes answers: _____

_____

_____

_____

FAMILY HISTORY: Any family history of any serious illnesses such as diabetes, high blood pressure, heart disease, or cancer: _____

_____

_____

HOSPITALIZATIONS/SURGERY: **NONE:**

DATE:	**CONDITION/SURGERY**
_____	_____
_____	_____
_____	_____

_____

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This is a 2 sided form – Please complete both sides

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

SOCIAL HISTORY: Occupation:_____

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

Is your home tobacco – and smoke-free? Y / N

Smoke: Y / N How Many Packs Per Day? _____ Age when started?: _____

Caffeine: Y / N Alcohol: Y / N If yes, how much/how often? _____

When was your last comprehensive health examination Date _____/_____/_____

Note: We recommend a comprehensive evaluation for healthy individuals every three years until age 40, every two years from ages 40 to 50 and annually after the age of 50. Patients with a chronic medical problem should have an annual health evaluation.

If you were born after 1957, have you had a second measles, mumps and rubella vaccination? Y / N

If you are at least 65 years old or have a chronic health problem, have you received the pneumococcal and flu vaccines? Y / N

If you are a female, do you do a monthly self-breast exam? Y / N

When was your last breast exam by your physician? Date: ____/____/____

Date of last mammogram: ____/____/____ Date of last pap smear: ____/____/____

Note: One out of every 10 women will get breast cancer. The best approach is early detection by doing a monthly self-breast exam, an annual breast exam by our physician and periodic mammograms.

Have you ever had colon cancer screening? i.e. colonoscopy ? *Y / N*

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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)