Liberty Park
Unit 9/10
282 Route 101
Amherst, NH 03031
Phone: 603-249-8883
Fax: 603-249-1107

The Concord Center
Suite 201
10 Ferry Street
Concord, NH 03301
Phone: 603-369-4530
Fax: 603-673-6300

Patient Registration

Legal Name: ______________________________ DOB: _______________
Nick Name: _______________________________
Address: ________________________________ SS#______-____-______
____
________________________________ Gender: M / F

Phone (please check preferred)
□ Home: __________________
□ Work: __________________
□ Cell: ____________________
Email: ___________________

Emergency Contact
Name:_________________________
Phone:_________________________
Relationship:____________________

May we leave a detailed message on voice mail at? Home / Work / Cell

Insurance Carrier: ____________________________________
Subscriber:________________________________ DOB: ______________
Identification Number:______________________ /__________
Group Number:__________________

*Please show your insurance card to the front desk at every visit.

Are you Medicaid Eligible? Yes / No
Are you under insured or uninsured? Yes / No

Previous Primary Care Provider

Name:_______________________________________
Address: ____________________________ Phone: _______________
____________________________ Fax #: _______________
____

*Please notify your insurance, if needed, for change in primary care provider.

Have you had your medical records transferred to us? Yes / No

If no, please ask the receptionist for a medical release form so that we may request them on your behalf. You will need the previous facilities name, address, phone and fax number.

Are you seeing us by referral for a consult only? Yes / No

If no, are you required to choose a PCP with your insurance? Yes / No
If yes, have you contacted the insurance company to do so?
Effective Date__________________

NAME: ________________________________ **DOB:** ___________________

Ethnicity:

Are you American Indian? Yes / No
Are you Alaskan Native? Yes / No
Other: ____

Language Spoken: ____

Do you have Advanced Directives?

Living Will: Yes / No
Durable Power of Attorney: Yes / No
Does our office have an embossed copy of these? Yes / No

Allergies:

1) Medication:_________________________ Reaction:_______________
2) Medication:_________________________ Reaction: _______________
3) Medication: ________________________ Reaction: _______________
4) Environmental: ____
5) Food: ____

Have you ever had Chicken Pox? Yes / No

What year or how old: _____________

Date of last immunization?

Influenza: Date________________________
Pneumovax: Date______________________
Tetanus: Date_________________________
Zostavax (Shingles): Date_______________

Household Members:

Name: ____
Relationship: __________________________ Age: ______
Name: ____
Relationship: __________________________ Age: ______
Name: ____
Relationship: __________________________ Age: ______
Name: ____
Relationship: __________________________ Age: ______
Name: ____
Relationship: __________________________ Age: ______

NAME: ________________________________ **DOB:** ___________________

Family History: **please check box and circle relationship to you**

PGF:Paternal Grandfather **PGM:Paternal Grandmother**
MGF:Maternal Grandfather **MGM:Maternal Grandmother**
M:Mother **F:Father** **B:Brother** **S:Sister**

Arthritis	☐	PGF	PGM	MGF	MGM	M	F	B	S
Asthma/COPD	☐	PGF	PGM	MGF	MGM	M	F	B	S
Cancer (type) ________________	☐	PGF	PGM	MGF	MGM	M	F	B	S
Coronary Artery Disease	☐	PGF	PGM	MGF	MGM	M	F	B	S
Depression/Anxiety	☐	PGF	PGM	MGF	MGM	M	F	B	S
Diabetes	☐	PGF	PGM	MGF	MGM	M	F	B	S
GI Disorders	☐	PGF	PGM	MGF	MGM	M	F	B	S
High Cholesterol	☐	PGF	PGM	MGF	MGM	M	F	B	S
Hypertension	☐	PGF	PGM	MGF	MGM	M	F	B	S
Migraines	☐	PGF	PGM	MGF	MGM	M	F	B	S
Obesity	☐	PGF	PGM	MGF	MGM	M	F	B	S
Stroke	☐	PGF	PGM	MGF	MGM	M	F	B	S
Other: ________________	☐	PGF	PGM	MGF	MGM	M	F	B	S

Social History:

Married/Single/Divorced/Widow (please circle)

Occupation: ______________________ Education: _________________

Habits:

Smoke Detector:	Yes / No						
C02 Detectors:	Yes / No						
Exercise:	Yes / No	Frequency?					
Alcohol:	Yes / No	How much? How often?		Quit:	Yes / No	Date:	
Tobacco:	Yes / No	How much?		Quit:	Yes / No	Date:	
Drug Use:	Yes / No			Quit:	Yes / No	Date:	
Caffeine Usage:	Yes / No	Cups per day?		Quit:	Yes / No	Date:	
Seatbelt Use:	Yes / No						
Helmet Use:	Yes / No						
Sunscreen:	Yes / No						

NAME: ______________________________ **DOB:** _________________

Do you follow a particular diet? Please circle

Diabetic
Low Calorie
Low Carb
Low Fat
Low Salt
Vegan
None

Have you traveled to other countries within the last year? Yes / No

Where: _____________________________ Date: ____________________
Where: _____________________________ Date: ____________________

Females Only:

When was your last menstrual period? ____________________
Number of Pregnancies? _______________
Number of Births? __________

Other Healthcare Providers (Complete if Appropriate)

Dentist: _____________________ Location: ___________ Last Visit: ______
Eye Doctor: __________________ Location: ___________ Last Visit: ______
Gynecologist: ________________ Location: ___________ Last Visit: ______
Urologist: ___________________ Location: ___________ Last Visit: ______
Orthopedist: _________________ Location: ___________ Last Visit: ______
Cardiologist: ________________ Location: ___________ Last Visit: ______
Dermatologist: _______________ Location: ___________ Last Visit: ______
Gastroenterologist: _____________Location: ___________ Last Visit: ______
Endocrinologist: _______________Location: ___________ Last Visit: ______

Medications: ***Please include all current medications, including over the counter and supplements**
(Use back of last page for additional medications)

Name: ___________________ Dose: _________ Frequency: __________
Name: ___________________ Dose: _________ Frequency: __________
Name: ___________________ Dose: _________ Frequency: __________
Name: ___________________ Dose: _________ Frequency: __________
Name: ___________________ Dose: _________ Frequency: __________
Name: ___________________ Dose: _________ Frequency: __________

NAME: ________________________________ **DOB:** ___________________

Past Medical History: please check box

Alcohol/Drug Use	☐	Hepatitis	☐
Bleeding/Clotting Tendencies	☐	High Blood Pressure	☐
Cancer	☐	Liver Disease	☐
Chronic Pain	☐	Lung Disease	☐
Congenital Defects	☐	Mononucleosis	☐
Convulsive Disorder	☐	Neurologic Disease	☐
COPD/Asthma	☐	Renal/Kidney Disease	☐
Diabetes	☐	Rheumatic Fever	☐
Depression	☐	Sleeping Disorder	☐
Gastrointestinal Disease	☐	Smoking History	☐
Genital/Urologic Disease	☐	Stroke	☐
Heart Attack	☐	Tuberculosis	☐
Heart Disease	☐		

Hospital/Surgical History:

Explain: ____

Date: ____________ Facility: ____________________________________

Explain: ____

Date: ____________ Facility: ____________________________________

Explain: ____

Date: ____________ Facility: ____________________________________

Other Pertinent Medical Information You Would Like To Share With Us?

____

____

____

____

Patient Signature: ________________________________

Date: ________________

Parental/Guardian Signature: ________________________________

Date: ________________

Signature of Reviewing Provider: _____________________________

Date: ________________