WRIGHT & ASSOCIATES
FAMILY HEALTHCARE
AFFILIATE OF DMC PRIMARY CARE

Liberty Park
Unit 9
282 Route 101
Amherst, NH 03031
Phone: 603.249.8883
Fax: 603.249.1107

Patient Registration

Legal Name: _____ DOB: _____
Nick Name: _____
Address: _____ SS#_____-____-_____
_____
_____
Birth Gender (circle): M / F
Identify As (circle or complete): He/She/They/Them _____

Phone (please check preferred) **Emergency Contact**
☐ Home: _____ Name:_____
☐ Work: _____ Phone:_____
☐ Cell: _____ Relationship:_____
Email: _____
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 uninsured? Yes / No

Race/Ethnicity:
Are you American Indian? Yes / No
Are you Alaskan Native? Yes / No
Other: _____

Language(s) Spoken: _____

Previous Primary Care Provider
Name:_____
Address: _____ Phone: _____
_____ Fax #: _____
_____
*Please notify your insurance, if needed, for change in primary care provider.

NAME: _____ DOB: _____

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_____

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.

Do you have Advanced Directives?

Living Will: Yes / No

Durable Power of Attorney: Yes / No

Does our office have a copy of these? Yes / No

Household Members:

Name: _____

Relationship: _____ Age: _____

Name: _____

Relationship: _____ Age: _____

Name: _____

Relationship: _____ Age: _____

Name: _____

Relationship: _____ Age: _____

Name: _____

Relationship: _____ Age: _____

NAME: _____ **DOB:** _____

PERSONAL MEDICAL INFORMATION

Reason for Today's Visit: _____

Past Medical History: Check box or write in current or previous health conditions

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	☐		

Allergies:

1) Medication:_____ Reaction:_____
2) Medication:_____ Reaction: _____
3) Medication: _____ Reaction: _____
4) Environmental: _____
5) Food: _____

Date of last immunization (please bring vaccination record to visit):

Influenza: Date _____
Pneumovax (PPSV23): Date _____
Prevnar (PCV13): Date_____
Tetanus/Tdap: Date _____
Shingrix (Shingles): Date _____

Have you ever had Chicken Pox? Yes / No

What year or how old: _____

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 (Type_____)	☐	PGF	PGM	MGF	MGM	M	F	B	S
Asthma/COPD (Circle)	☐	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 (Type_____)	☐	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: _____

Health Prevention/Health Promotion:

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?

What type of diet?_____

Females Only:

When was your last menstrual period? _____

Number of Pregnancies? _____

Number of Births? _____

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

Where:_____ Date: _____

Where: _____ Date: _____

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: _____

Hospital/Surgical History:

Explain: _____
Date: _____ Facility: _____
Explain: _____
Date: _____ Facility: _____
Explain: _____
Date: _____ Facility: _____

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: _____

NAME: _____ DOB: _____

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

_____

_____

_____

Patient Signature: _____
Date: _____

Parental/Guardian Signature: _____
Date: _____

Signature of Reviewing Provider: _____
Date: _____