



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

Patient Registration

Name: _____ DOB: _____

Address: _____

Gender: M / F

Phone Home: _____

Work: _____

Cell: _____

Insurance: _____

Identification Number: _____

Subscriber: _____

Group Number: _____

Are you Medicaid Eligible? ___ Yes ___ No

Are you under insured or uninsured? ___ Yes ___ No

Previous Primary Care Provider: _____

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.

Ethnicity:

Are you American Indian? ___ Yes ___ No

Are you Alaskan Native? ___ Yes ___ No

Allergies:

1) Medication: _____ Reaction: _____

2) Medication: _____ Reaction: _____

3) Medication: _____ Reaction: _____

4) Environmental: _____

5) Food: _____

Patient Name: _____ DOB: _____

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: _____

Past Medical History: please circle

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

Hospital/Surgical History:

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

Family History: please circle

Diabetes Coronary Artery Disease Hypertension Stroke Cancer
High Cholesterol Asthma/COPD Arthritis Obesity
Other: _____

Patient Name: _____ DOB: _____

Social History:

Married/Single/Divorced/Widow (please circle)

Occupation: _____

Education: _____

Household Members:

Name: _____

Relationship: _____ Age: _____

Name: _____

Relationship: _____ Age: _____

Name: _____

Relationship: _____ Age: _____

Habits:

Smoke: Yes / No How much? _____ Quit: Yes / No Date: _____

Alcohol: Yes / No How much? _____ How often? _____

Quit: Yes / No Date: _____

Drug Use: Yes / No Quit: Yes / No Date: _____

Caffeine Usage: Yes / No Cups per day? _____

Exercise: Yes / No Frequency? _____

Seatbelt Use: Yes / No Helmet Use: Yes / No

Sunscreen: Yes / No Smoke/Carbon Monoxide Detectors: Yes / No

Do you follow a particular diet? Please circle

Low Fat Low Carb Diabetic Low Salt Vegan Low Calorie None

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

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

Where: _____ Date: _____

Where: _____ Date: _____

Patient Name: _____ DOB: _____

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: _____

Have you ever had Chicken Pox? Yes / No What year or how old: _____

Date of last immunization?

Tetanus: _____ Pneumovax: _____ Influenza: _____

Females Only:

When was your last menstrual period? _____
Number of Pregnancies? _____ Number of Births? _____

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

Patient Signature: _____

Date: _____

Signature of Reviewing Provider: _____

Date: _____