



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

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: _____
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

Patient 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: _____

Patient 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	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Asthma/COPD	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Cancer (type) _____	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Coronary Artery Disease	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Depression/Anxiety	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Diabetes	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
GI Disorders	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
High Cholesterol	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Hypertension	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Migraines	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Obesity	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Stroke	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S
Other: _____	<input type="checkbox"/>	PGF	PGM	MGF	MGM	M	F	B	S

Social History:

Married/Single/Divorced/Widow (please circle)

Occupation: _____ Education: _____

Habits:

Smoke /Fire	Yes / No						
Carbon Monoxide Detectors:	Yes / No						
Exercise:	Yes / No	Frequency?					
Alcohol:	Yes / No	How much? How often?		Quit:	Yes / No	Date:	
Smoke:	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						

Patient 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: _____

Patient Name: _____ DOB: _____

Past Medical History: please check box

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

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: _____