57 Northeastern Blvd Ste 202
Nashua, NH 03062
Phone: 603.821.4009 Fax: 603.821.4039

Patient Registration

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

Race/Ethnicity:
Are you American Indian? Yes / No **Language(s) Spoken: _____**
Are you Alaskan Native? Yes / No **Religious Preference:_____**
Other: _____

Contact Info: (please check preferred) **Emergency Contact**
☐ Home: _____ Name:_____
☐ Work: _____ Phone:_____
☐ Cell: _____ Relationship:_____
Email: _____ *Please be sure to sign up for our FMH portal.
May we leave a detailed message on voice mail: Yes / No At: Home / Work / Cell

☐ Insured ☐ Self Pay ☐ Enrolled in DPC Membership: skip to corresponding sections

Insurance Information:
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

NAME: _____ DOB: _____

Direct Primary Care Enrollment Information:
Enrollment Start Date: ____/____/_____
Enrolled through: ☐ Employer (list employer):_____
☐ Individual ☐Family Member (list family member):_____
☐ Other:_____

Previous Primary Care Provider:
Name:_____ Phone: _____
Address: _____ Fax #: _____
_____ Date of last visit:_____

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? Yes / No
Effective Date of Referral or New PCP: _____
*Please notify your insurance, if needed, for change in primary care provider.
*Failure to notify your insurance, if needed, for change in primary care provider may result in denial of your insurance claims or ability to get authorizations.

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.

How did you hear about us? ☐ Family Member/Friend ☐ Social Media ☐ The Internet ☐ News Article/Print Media ☐ Eye Doctor/Dentist/Chiropractor ☐ Other:_____

Do you have Advanced Directives?
Living Will: Yes / No
Durable Power of Attorney: Yes / No -or- Health Care Proxy Yes / No
Does our office have a copy of these? Yes / No
If no, please visit https://www.healthynh.org/index.php/publications.html and click on Advance Care Planning Guide

NAME: _____ DOB: _____

PERSONAL MEDICAL INFORMATION

Reason for Today's Visit: _____

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

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

Allergies:

Medication:_____ Reaction:_____
Medication:_____ Reaction: _____
Medication: _____Reaction: _____
Environmental: _____ Reaction:_____
Food: _____Reaction:_____

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
Autoimmune Disorder (Type_____)	☐	PGF	PGM	MGF	MGM	M	F	B	S

NAME: _____ DOB: _____

Cancer (Type_____)	☐	PGF	PGM	MGF	MGM	M	F	B	S
Coronary Artery Disease	☐	PGF	PGM	MGF	MGM	M	F	B	S
Depression/Anxiety (Circle)	☐	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//Divorced/Separated/Widowed/Single (please circle)
Highest Level of Education: _____ Occupation: _____
Current Work/Student (please circle) Status: Full-Time/Part-Time/Retired:_____
Activities/Hobbies/Sports: _____

Household Members:

Name: _____
Relationship: _____ Age: _____
Name: _____
Relationship: _____ Age: _____
Name: _____
Relationship: _____ Age: _____
Name: _____
Relationship: _____ Age: _____
Name: _____
Relationship: _____ Age: _____

Pets: Dog(s) Type _____ How Many_____
Cat(s) Type _____ How Many_____
Other(s) Type _____ How Many_____

NAME: _____ DOB: _____

Health Prevention/Health Promotion:

Exercise:	Yes / No	Frequency?					
Now/Past Tobacco Use	Yes / No	Packs Per Day:		Quit?	Yes / No	Date:	
Tobacco/Smoke Exposure	Yes / No	Explain:					
Now/Past Vaping	Yes / No	Frequency?		Quit:	Yes / No	Date:	
Alcohol:	Yes / No	How Much? Frequency?		Quit:	Yes / No	Date:	
Now/Past Drug Use:	Yes / No	Type:		Quit:	Yes / No	Date:	
Risk for STD	Yes / No						
Caffeine Consumption	Yes / No	Cups per day:					
Hours of Sleep							
Special Diet/Restrictions	Yes / No	Explain:					
Seatbelt Use	Yes / No						
Helmet Use	Yes / No						
Sunscreen Use	Yes / No						
Guns in the home	Yes / No	Secure/In a Safe:	Yes / No				
Smoke Detectors	Yes / No						
CO2 Detectors	Yes / No						

Travel History:

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

Where:_____ Date: _____

Where: _____ Date: _____

Current Medications/Supplements including over the counter:

Medication/Supplement:	Dose:	Frequency of Use:	Reason for taking:

NAME: _____ DOB: _____

Females Only:

Date of last menstrual period: _____ Regular/Irregular (circle one)
Age of Onset: _____ Length of Flow: _____ Frequency:_____
Number of Pregnancies: ___ Number of Births:___ Pregnancy Complications: Yes / No
Type of Delivery: Vaginal / C-Section (circle one) Labor Complications: Yes / No
Current Contraception: Yes / No Type:_____

Hospitalization/Surgical History:

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

Diagnostic Studies:

Procedure:	Done:	Type:	Date:	Results:
Colonoscopy	Yes / No	Routine Screen/Diagnostic		Normal/Abnormal
Mammogram	Yes / No	Routine Screen/Diagnostic		Normal/Abnormal
Bone Density	Yes / No	Routine Screen/Diagnostic		Normal/Abnormal
Upper Endo/EGD	Yes / No	Routine Screen/Diagnostic		Normal/Abnormal
Biopsy	Yes / No	Site:		Normal/Abnormal

Health Maintenance / Past Immunization (please bring vaccination record to visit):

Influenza (Flu) Vaccine: Date _____
Covid-19 Vaccine: Date _____ Booster: Date _____
Pneumovax (PPSV23): Date _____
Prevnar (PCV13): Date_____
Tetanus/Tdap: Date _____
Shingrix (Shingles): Date _____
Hep B Series Vaccine Dates _____, _____,_____ Age:_____
Have you had the Chicken Pox Virus: Yes / No Age:_____

NAME: _____ DOB: _____

Other/Past Healthcare Providers:

Specialist	Location	Date of Last Visit
Dentist		
Eye Doctor		
Gynecologist		
Urologist		
Orthopedist/Podiatrist		
Cardiologist		
Dermatologist		
Gastroenterologist		
Rheumatologist		
Endocrinologist		
Other		

Do you have concerns or other pertinent medical information you would like to share or have addressed at today's visit? If so, please explain below:

_____

_____

_____

Patient Signature: _____ Date: _____

Parental/Guardian Signature: _____ Date: _____
Relationship: _____

Signature of Reviewing Provider: _____ Date: _____