☐ 841 Central Street, Franklin, NH 03235 Tel: (603) 934-1464 Fax: (603) 934-1465
☐ 22 Strafford Street, Laconia, NH 03246 Tel: (603) 366-1070 Fax: (6030 366-1071

I am interested in: ❑ **Primary Care Services** ❑ **Behavioral Health Services** ❑ **MAT** (Medication Assisted Treatment)

New Patient Registration

Patient Name:_____ Date of Birth: _____/_____/_____

Address:_____
(Street) *(City/State/Zip)* ❑ I am homeless

Home #:(____) _____ Cell # (____)_____ E-mail:_____

Emergency Contact:_____ Relationship:_____

Contact Phone(s):_____

Gender at Birth: ❑Male ❑Female ❑Decline Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Is your primary language English? ❑Yes ❑No If No, what is your primary language? _____

Do you need an interpreter? ❑Yes ❑No Are you hearing impaired? ❑Yes ❑No

Personal

HealthFirst Family Care Center receives state and federal funding to support the services offered to patients. We are asked to report on the general financial status and public health details of our patient panel. Your assistance in completing the following information will help us apply for future grant funding. All information provided is confidential. Thank you,

Race: ❑American Indian/Alaska Native ❑Asian ❑African American ❑Native Hawaiian ❑White ❑Patient Declined

Ethnicity: ❑Hispanic/Latino ❑Non Hispanic/Latino ❑Patient Declined Are you a Veteran? ❑ Yes ❑ No

Gender Identity: Do you think of yourself as? ❑Male ❑Female ❑Female-to-Male/Transgender Male
❑Male-to-Female/Transgender Female ❑ Other ❑ Decline

Sexual Orientation: Do you think of yourself as? ❑Straight or Heterosexual ❑Lesbian, Gay or Homosexual ❑Bisexual
❑Something else ❑Do not know ❑ Decline

Employment Information

Employment Status: ❑Full time ❑Part time ❑Unemployed ❑Disabled ❑Retired (Date:)_____

Employer's Name:_____ Phone #: (____) _____

Address:_____ Occupation:_____

Person responsible for the bill or Is the primary insurance holder (If different then the patient)

Parent/Guardian:_____ Date of Birth: _____/_____/_____

Employer Name & Address: _____ Phone #: (____) _____
(Name/Street/City/State)

If the patient is a minor (under the age of 18) please complete this section

Mother's Name:_____ Daytime Phone #:_____

Father's Name:_____ Daytime Phone #:_____

Patient Name: **Date of Birth:** / /

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Insurance Information

Primary Insurance : _____ ID Number:_____

Group #: _____ Policy Holder Name: _____ Date of Birth: _____

Employer of Policy Holder: _____ City: _____

Secondary Insurance: _____ ID Number:_____

Group #: _____ Policy Holder Name: _____ Date of Birth: _____

Employer of Policy Holder: _____ City: _____

Work Related Injury

Are you being seen for a work related injury? ❑ Yes ❑ No If Yes, when did the injury occur?_____

Employer:_____ Contact person:_____

Motor Vehicle Accident Injury

Are you being seen for an injury that occurred in a Motor Vehicle Accident? ❑ Yes ❑ No Date of Accident:_____

Payment Options

I do not have health insurance coverage at this time. I understand that I will be expected to pay the full cost of services provided at HealthFirst Family Care Center at the time of service unless I have made other arrangements for payment.

❑ Yes ❑ No I will request a payment plan for services provided

❑ Yes ❑ No I would like to receive information about the HealthFirst Discount Program or other financial assistance options.

How did you hear about HealthFirst Family Care Center?

❑ Friend/Family ❑ Hospital ❑ Social media (Facebook) ❑ Social Service Agency ❑ Doctor's Office

❑ Radio Ad ❑ Website ❑ Newspaper/Billboard Ad ❑ Other:_____

This is to certify that the above information is true and I hereby authorize HealthFirst Family Care Center to verify any of the information I have provided.

Signature: _____ **Today's Date**: _____

Patient/Parent/Guardian (Must be 18 years or older)