❑ 841 Central Street, Franklin, NH 03235 Tel: (603) 934-1464 Fax: 833-949-3968
❑ 22 Strafford Street, Laconia, NH 03246 Tel: (603) 366-1070 Fax: 833-949-3973
❑ 18 Roberts Rd, Canaan, NH 03741 Tel: (603) 523-4343 Fax: 833-449-2582

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

New Patient Registration **OFFICE RECEIVED DATE:**

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

Gender at Birth: ❑Male ❑Female Preferred Name: _____

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

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

How would you like to receive appointment reminders? ❑ Call ❑ Text ❑ Both ❑ Neither/Decline

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.

Language: ❑ English ❑ French ❑ Spanish ❑Other: _____ Do you need interpreter services? ❑ Yes ❑ No

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

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Decline ❑Other: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner

Sexual Orientation: ❑ Straight or Heterosexual ❑ Lesbian, Gay or Homosexual ❑ Bisexual ❑ Something else
❑ Do not know ❑ Decline

Gender Identity: ❑ Male ❑ Female ❑ Female-to-Male/Transgender Male ❑ Male-to-Female/Transgender Female
❑ Gender Non-Conforming ❑ Other ❑ Decline

Pronoun: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Decline

Are you an Agricultural Worker? ❑ Yes ❑ No ❑ Decline **Migrant Worker:** ❑ Yes ❑ No **Seasonal Worker:** ❑ Yes ❑ No

Are you homeless? ❑ Yes ❑ No ❑ Decline If yes, ❑Homeless shelter ❑ Transitional ❑ Doubling Up ❑ Street
❑Other: _____

Are you a Veteran? ❑ Yes ❑ No ❑ Decline

Do you currently reside in public housing? ❑ Yes ❑ No ❑ Decline

Check off all that apply:

❑ I live alone ❑ I do not have a caregiver ❑ I need assistance for transfer/fall risk ❑ I have a lifeline / medic alert
❑ I have advance directives ❑ I am hearing impaired ❑ I am vision impaired
❑ I will need an interpreter for: ❑ Language ❑ Sign Language

Emergency Contact:_____ Relationship:_____
Contact Phone(s):_____

Employment Information

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

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

Address:_____ Occupation:_____

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

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

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 #:_____

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

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

Address: _____ Phone #: (____) _____

Employer Name & Address: _____ Phone #: (____) _____

(Name/Street/City/State)

Insurance Information

Primary Insurance: _____ ID Number:_____

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

Secondary Insurance: _____ ID Number:_____

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

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 currently. 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)

Printed name:_____