



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

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)  
Home #: (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_  
How would you like to receive appointment reminders?  Call  Text  Both  Neither/Decline

**Personal**

*We ask for the following personal information to help us provide the best possible care and resources for your health needs. Your answers are private and protected.*

**Language:**  English  French  Spanish  Other: \_\_\_\_\_ Do you need interpreter services?  Yes  No  
**Race:**  American Indian/Alaska Native  Asian  African American  White  Other: \_\_\_\_\_  Decline  
**Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino  Other: \_\_\_\_\_  Decline  
**Marital Status:**  Married  Single  Divorced  Separated  Widowed  Partner  
**Are you an Agricultural Worker?**  Yes  No  Decline  
**Household Living Arrangement**  Rent  Own  Shelter  Transitional  Doubling Up  Street  Decline  
**Are you a Veteran?**  Yes  No  Decline

**Check off all that apply:**  
 I live alone  I 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

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
Contact Phone(s): \_\_\_\_\_

**Employment Information**

Employment Status:  Full time  Part time  Unemployed  Disabled  Retired (Date: \_\_\_\_\_)  
Employer's Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

**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**



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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:** \_\_\_\_\_