WAKEFIELD FAMILY MEDICINE

131 Meadow Street • Sanbornville, NH 03872 • Phone 603-871-8227 • Fax 603-871-8285

NEW PATIENT REGISTRATION

Please complete all applicable sections. If a question does not apply, write "N/A."

1. Patient Information

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ F ☐ M ☐ Other

Address: _____ Apt/Unit: _____

City: _____ State: _____ ZIP: _____ County: _____

Home Phone: _____ Cell Phone: _____

2. Contact & Communication Preferences

Email: _____ Preferred language: _____

Preferred contact: ☐ Phone ☐ Text ☐ Email Okay to leave voicemail? ☐ Yes ☐ No

May we send appointment reminders? ☐ Yes ☐ No Best time to reach you: _____

Relationship status: ☐ Single ☐ Married/Partnered ☐ Other Pronouns (optional): _____

3. Emergency Contact

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____

4. Insurance Information

Primary Insurance: _____ Member ID: _____

Policy Holder: _____ Relationship to patient: _____

Policy Holder DOB: _____ Group #: _____

Effective date: _____

Secondary Insurance (if applicable): _____ Member ID: _____

Policy Holder: _____ Relationship to patient: _____

Please provide copies of your insurance card(s) and photo ID, if requested.

5. Responsible Party / Billing Information (if different from patient)

Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____ DOB: _____

6. Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

Address / Location: _____ City: _____

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NEW PATIENT ADULT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Previous primary care provider: _____

Office / Practice Name: _____

Contact Information: _____

Date of Last Physical: _____

1. Medical History

Please check any conditions you have been diagnosed with or are currently being treated for:

☐ Asthma ☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ Heart disease
☐ Kidney disease ☐ Liver disease ☐ Thyroid condition ☐ Cancer ☐ Orthopedic
☐ Mental Health Disorders ☐ GI Disorders ☐ Respiratory Disorders ☐ Neurologic Disorders

☐ Communicable Diseases ☐ Other: _____

Past surgeries /Recent hospitalizations: _____

_____

Date of Last Routine Physical_____

2. Allergies

Medication allergies: _____

Reaction(s): _____

Other allergies / Food sensitivities: _____

3. Current Medications

Please list prescription medications, over-the-counter medications, vitamins, and supplements.

Medication / Supplement	Dose	How Often	Reason / Notes

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NEW PATIENT PREVENTATIVE CARE

Patient Name: _____ Date of Birth: _____

Please list the most recent date known. If you are unsure, write "Unknown."

1. Dental & Eye Care

Dentist Name: _____ Last Visit: _____

Eye Doctor Name: _____ Last Visit: _____

2. Preventative Screening & Testing

Colonoscopy (Cologuard)	Date: _____
Lung Cancer Screening	Date: _____
Diabetes Screening	Date: _____
Imaging / Lab Studies	Date: _____
Mammogram	Date: _____
GYN / Pap Test (Female)	Date: _____
Bone Density	Date: _____
Prostate Screening (Male)	Date: _____

3. Immunizations — Last Known Date

Tetanus / Tdap	Date: _____
Pneumovax 23	Date: _____
COVID-19	Date: _____
Shingles	Date: _____
Influenza	Date: _____
RSV	Date: _____
Prevnar 13	Date: _____

4. Additional Preventative Care Information

Please list any other screening, testing, or immunization information you would like your care team to know:

_____

_____

_____

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NEW PATIENT PREVENTATIVE CARE (continued)

5. Family History

☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Cancer ☐ High blood pressure ☐ Mental health conditions

☐ Other: _____

6. Social & Lifestyle Information

Tobacco / nicotine: ☐ Never ☐ Former ☐ Current

Alcohol: ☐ None ☐ Occasional ☐ Daily

Recreational drugs: ☐ No ☐ Yes

Exercise: ☐ Rarely ☐ Sometimes ☐ Regularly

Occupation: _____

Who do you live with? _____

Anything about your lifestyle or circumstances you would like your care team to know?

_____

7. PHQ-2 Depression Screening

Over the last 2 weeks how often have you been bothered by any of the following? (Please circle your answer):

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

_____

_____

Office Use Only:

PHQ-2 Score: _____

Suicide Prevention Plan Initiated: YES or NO

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Authorization to obtain medical records from another healthcare facility to Wakefield Family Medicine

I authorize Wakefield Family Medicine, PLLC and its designated staff to request and receive protected health information including medical records from the facility or provider listed below for purposes of coordinating and continuing my healthcare.

1. Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

2. Records Requested From

Facility / Provider Name: _____ Phone: _____

Address: _____ Fax: _____

Dates of Service. From: _____

City: _____ State: _____ ZIP: _____ To: _____

3. Records to Be Released

Please release the following records, as applicable:

☐ Complete medical record ☐ Most recent office notes ☐ Specialist notes ☐ Laboratory results

☐ Imaging / reports ☐ Medication list ☐ Immunization records ☐ Hospital / ER records

☐ Other: _____

4. Purpose of Disclosure:

☐ Transfer / establish care ☐ Continuity of care ☐ Other: _____

5. Authorization

I understand that the information requested may include protected health information including information that may be viewed as sensitive, such as alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. Specify any information you want to exclude:_____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

I understand that treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing this authorization.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by federal privacy regulations, except where otherwise applicable.

6. Patient / Legal Representative

Patient / Legal Representative Name:

_____ Relationship: _____

Signature: _____ Date: _____

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PERMISSION TO SPEAK WITH A DESIGNEE

Use this form to give Wakefield Family Medicine permission to speak with the person(s) you designate about your medical and/or financial information.

Patient Name: _____ Date of Birth: _____

1. Designee Information

I give permission for Wakefield Family Medicine to communicate with the following person(s):

Name	Relationship	Phone	Email (optional)

2. Information I Authorize the Practice to Discuss

Please check all that apply:

☐ Medical / health information ☐ Appointments and scheduling

☐ Test, laboratory, and imaging results ☐ Medications and treatment information

☐ Billing, balances, insurance, and other financial information

☐ All of the above

3. Preferred Communication

☐ Phone ☐ Voicemail ☐ In-person ☐ Text ☐ Email

4. Limits or Special Instructions

Please describe any information you do NOT want shared with the designee(s) listed above:

_____

5. Expiration and Revocation

This permission will remain in effect until I revoke it in writing, unless I specify an earlier expiration date below.

Expiration date (optional): _____

I understand that I may revoke this permission in writing at any time. Revocation is not effective for actions already taken in reliance on this permission.

6. Patient Authorization

I understand that by signing below, I am authorizing Wakefield Family Medicine to communicate with the designee(s) named on this form within the limits I have selected. I understand that the practice will use reasonable safeguards when communicating my information.

Patient / Legal Representative Signature:

_____ Date: _____

Printed Name:

_____ Relationship: _____

A copy of this completed form may be retained in the patient's medical record.