WENTWORTH HEALTH PARTNERS

Patient Annual Review Form

Preferred language to discuss your care: _____

Would you like an interpreter? ☐ No ☐ Yes (language: _____)
Check if any of the following apply: ☐ Deaf/Hard of Hearing ☐ Visually Impaired ☐ N/A
Preferred learning style(s): ☐ Visual (reading) ☐ Verbal (hearing) ☐ Demonstration

PATIENT INFORMATION

Name _____ Date of Birth_____
Street Address: _____ City, State, Zip:_____
Mailing Address:_____ City, State, Zip: _____
Home Phone: # (____)_____ Work: # (____)_____ Cell: # (____)_____
Marital Status: (**Please check one**) ☐Single ☐Married ☐Divorced ☐Separated ☐Widow(er)

Emergency Contact: Used Only If Unable To Reach You - No Health Information Will Be Shared

Name: _____ Phone: # (___) _____ Relationship to Patient:_____

Parent/Legal Guardian (If patient is under 18 or over 18 and unable to make decisions for him/herself)

Name of Parent/Guardian 1: _____
Street Address _____
Mailing Address _____
City, State, Zip _____
Date of Birth _____
Best phone # to reach you (_____) _____
Relationship to Patient _____

Name of Parent/Guardian 2:_____
Street Address _____
Mailing Address _____
City, State, Zip _____
Date of Birth _____
Best phone # to reach you (_____) _____
Relationship to Patient _____

Parties listed above both have legal custody and rights in decision making for the minor. **If not, please provide a copy of relevant court documents defining responsibilities over a minor. Please provide court documents if you are legal guardian for patient over 18.**

Do you currently participate in a clinical trial? ☐Yes ☐No
☐Seacoast Cancer Center ☐Other: _____

Advance Directives (please provide us with copies of all documents):

1. Do you have a durable power of attorney for health care (DPOAH), which names another individual to make health care decisions for you if you are unable to? ☐Yes or ☐No

2. Do you have a living will that instructs your health care providers whether to give life sustaining treatment if you are near death or are permanently unconscious, with no hope for recovery? ☐ Yes or ☐No

If you answered No to any of the above, please ask us for an information packet.

Financial Assistance
If you require financial assistance to enable you to afford the health care that you need, please ask any staff member and they will provide you with a WDH Financial Assistance Application and a copy of the Financial Assistance Policy. **If I am a self-pay patient pursuant to RSA 151:12-b, I will receive a discount off charges at the time of billing that is consistent with discounts provided to patients covered by commercial health insurance as required by state law (NH RSA 151:12-b).** An additional prompt pay discount for self-pay balances and balances after insurance is available if payment is received within 30 days of receiving a bill**.** For questions regarding your bill, please call **1-855-762-5219**. For questions regarding Financial Assistance, please call (603) 740-3342.

I confirm that the above information is current and accurate.

Patient Name (please print) _____ DOB_____

Patient Signature_____ Date _____

Legal Guardian (please print) _____

Legal Guardian Signature_____ Date _____