WENTWORTH HEALTH PARTNERS

PATIENT ANNUAL REVIEW FORM

Report Patient Supplied Data

Patient Identification Area

Preferred language to discuss your care: _____ Language spoken at home: _____

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

Legal Name:_____ Date of Birth: _____

Preferred Name: _____

Sex Assigned at Birth: ❑ Male ❑ Female ❑ Intersex Legal Gender: ❑ Male ❑ Female ❑ X ❑ Other: _____

Gender Identity: (**Please check all that apply**) ❑ Male ❑ Female ❑ Gender Queer ❑ Non-Binary ❑ Agender

❑ Other: _____ ❑ **Choose not to disclose**

Pronouns: (**Please check all that apply**) ❑ He/Him/His ❑ She/Her/Hers ❑ They/Them ❑ Other: _____

Sexual Orientation: ❑ Straight/Heterosexual ❑ Gay ❑ Lesbian ❑ Bisexual ❑ Pansexual ❑ Asexual

Street Address: _____ City, State, Zip:_____

Mailing Address: _____ City, State, Zip: _____

Home Phone: # (____) _____ Work: # (____) _____ Cell: # (____) _____

Marital Status: (**Please check one**) ❑ Single/Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widow(er) ❑ Partner

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:_____ Name of Parent/Guardian 2: _____

Street Address: _____ Street Address: _____

Mailing Address:_____ Mailing Address: _____

City, State, Zip:_____ City, State, Zip: _____

Date of Birth:_____ Date of Birth: _____

Best phone # to reach you (_____)_____ Best phone # to reach you (_____) _____

Relationship to Patient: _____ 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 Wentworth-Douglass Hospital 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)** . For questions regarding your bill, please call 617-726-3884. 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: _____

I consent to evaluation and treatment by any provider affiliated with WHP. I hereby authorize release of medical information that is necessary for my further treatment and for the purpose described in the Partners HealthCare Notice of Privacy Practices. WHP providers may query databases that contain information about current medications provided by other providers or through our pharmacy.