WENTWORTH HEALTH PARTNERS

Patient Registration Form

Full Version – Use For New Patients/Initial Visit

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

Patient Information

Name:_____Date of Birth: _____ Social Security #: _____
Sex: □Male □Female Mother's Maiden Name: _____
Street Address: _____ City, State, Zip:_____
Mailing Address:_____ City, State, Zip: _____
Marital Status: (**Please check one**) □ Single □ Married □ Divorced □ Separated □ Widow(er)
Home Phone # (____)_____ Work # (____)_____ Cell # (____)_____
What is the preferred number at which to reach you? □ Home □ Work □ Cell
For cell phones, do you have text capability? □ Yes □ No
How did you hear about our practice? _____
Primary Care Provider: _____Primary Dental Provider:_____

For WHP Patient Portal Use *(Online access to request appointments, refills, receive lab results, immunization records, etc. Terms and Conditions for Use are posted on our practice website or available by request at our office)*
E-Mail Address: _____

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:_____

□ Married □ Divorced □ Separated □ Not Married □ Civil Union
(Please provide a copy of relevant court documents if you claim sole legal custody of a minor or are the legal guardian for patient over 18.)

Primary Insurance Name:_____ **Secondary Insurance Name:**_____
Name of Subscriber: _____ Name of Subscriber :_____
Subscriber's Address If Different From Patient's: Subscriber's Address If Different From Patient's:
_____ _____
Subscriber's Date of Birth:_____ Subscriber's Date of Birth: _____
Relationship to Patient:_____ Relationship to Patient: _____
Employer :_____ Employer: _____

Patient Name:_____ Date of Birth: _____

Race (Please Check One) or □ Decline

□ American Indian or Alaskan Native
□ Asian
□ Black or African American
□ Hispanic
□ Indian
□ Multi-Racial
□ Native Hawaiian or Other Pacific Islander
□ White
□ Unknown/Unavailable

Ethnicity (Please Check One) or □ Decline

□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown/Not Reported
□ Unavailable

Language (Please Check One) or □ Decline

□ English
□ Arabic
□ Balinese
□ Bengali
□ Bosnian
□ Bulgarian
□ Burmese
□ Chinese
□ Chamic Languages
□ Dutch
□ French
□ German
□ Greek
□ Gujarati
□ Hebrew
□ Hindi
□ Hungarian
□ Igbo
□ Igala
□ Indonesian
□ Indo-European
□ Italian
□ Japanese
□ Kamba
□ Kabardian
□ Khmer
□ Khotanese
□ Korean
□ Lao
□ Lushai
□ Malayalam
□ Marathi
□ Mandar
□ Minangkabau
□ Neopolitan Italian
□ Nepali
□ Nyoro
□ Old Norse
□ Panjabi
□ Persian
□ Philippine (Other)
□ Polish
□ Portuguese
□ Provencal
□ Romani
□ Romanian
□ Russian
□ Sign Languages
□ Spanish
□ Swahili
□ Swedish
□ Tai (Other)
□ Tamil
□ Telugu
□ Tagalog
□ Thai
□ Turkish
□ Urdu
□ Vai
□ Vietnamese
□ Unknown
□ Other: _____

Religion (Please Check One) or □ Decline

□ Anglican
□ Atheist
□ Baha'i
□ Baptist
□ Buddhist
□ Christian
□ Congregational
□ Conservative Jewish
□ Episcopal
□ Evangelical
□ Greek Orthodox
□ Hindu
□ Judaism
□ Jehovah's Witness
□ Lutheran
□ Maronite Catholic
□ Methodist
□ Mormon / Latter Day Saints
□ Muslim / Islam
□ Pentecostal
□ Presbyterian
□ Protestant
□ Quaker / Friends
□ Roman Catholic
□ Unitarian Universalist
□ United Church of Christ
□ Wiccan
□ Non-Religious
□ No Preference
□ Unknown
□ Other: _____

Patient Name:_____ Date of Birth:_____

Advance Directive is a legal document with instructions you give regarding your future care if you are unable to make decisions about your care.
There are two sections; you may have completed one or both of the sections:

1. *Durable Power of Attorney for Health Care (DPOAH)* - you name another individual to make healthcare decisions for you when you are unable to. Your provider determines that you can no longer make decisions for yourself and activates the DPOAH.
2. *Living Will* - you instruct your health care provider to give no life-sustaining treatment if you are near death or are permanently unconscious, with no hope for recovery.

Do you have an Advance Directive?	☐ Yes ☐No	If Yes, **please provide us a copy**.
Do you only have a Living Will?	☐ Yes ☐No	If Yes, **please provide us a copy.**
Do you only have a Durable Power of Attorney for health care?	☐Yes ☐No	If Yes, **please provide us a copy.**
Do you have a Durable General Power of Attorney for finances?	☐Yes ☐No	If Yes, **please provide us a copy**

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.

Insurance Authorization and Assignment of Benefits
While we participate with many insurance plans, if we do not participate with your insurance carrier, you will be responsible for the entire balance for all services rendered. If we participate with your insurance carrier, you will be responsible for any co-payments and/or deductibles at the time the services are rendered. I authorize and assign insurance benefit payment directly to the practice for any medical services I receive. I understand and agree that I am ultimately responsible for the charges on my account for any professional services rendered. I will be responsible for payment in full of all balances not paid by my insurance company. In an effort to help ensure accurate insurance billing, we ask that you present your insurance card and photo ID at each visit. Acceptable forms of payment are cash, check, debit and credit card (MasterCard, Visa, and Discover).

Partners HealthCare Notice of Privacy Practices
I have received/was offered a copy of the Partners HealthCare Notice of Privacy Practices. The Partners HealthCare Notice of Privacy Practices describes how my health information may be used or disclosed and explains my rights as a patient. I understand that I should read this document carefully and that it may be changed at any time. I may obtain a copy of the Partners HealthCare Notice of Privacy Practices by calling the practice. This practice uses an electronic medical record that is shared with Wentworth-Douglass Hospital and other affiliated practices.

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.

Patient Name or Legal Guardian (please print) _____

Patient or Legal Guardian Signature_____ Date _____