# Wakefield Family Medicine

131 Meadow Street
Sanbornville, NH 03872
**(603) 871-8227**

**New Patient Registration**

## PATIENT DEMOGRAPHICS

Full Name: ______________________________

Date of Birth: ______________________ Gender: ______________

Mobile Phone: ______________________ Home Phone: ______________

Email: ______________________________

Current Physical Address: ______________________________

______________________________

Current Mailing Address (if different): ______________________________

## PRIMARY INSURANCE

Insurance Carrier Name and Type of Plan: ______________________________

Member ID #: ______________________ Group #: ______________

Effective Date: ______________________

Co-Pay Amount: ______________________

## SECONDARY INSURANCE

Insurance Carrier Name and Type of Plan: ______________________________

Member ID #: ______________________ Group #: ______________

Effective Date: ______________________

Subscriber Name and DOB: ______________________________

Employer Name: ______________________________

Parent/Guardian Name: ______________________________

Emergency Contact: ______________________ Phone: ______________

Preferred Pharmacy: ______________________________

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**Authorization to Release Protected Health Information**
**Obtaining Records from a Facility**

Name: ______________________________________ DOB:________________

Mailing Address: ____________________________________________________

Physical Address: ___________________________________________________

Phone: Home ______________ Cell_____________ Work ____________________

Release for Dates of Service: _______ to _______ Reason for Request:______________

Type of Records Requested: (please check all that apply)

__ Entire Medical Record __ Office Notes __Lab Results __Imaging Results

__ Medications/Pharmacy __Mental Health__ Substance Abuse __ Procedure/Surgical Notes

**Please Do Not Send CD's**

To Be Obtained From:

Facility______________________________________________________________

Address: _____________________________________________________________

PH: _________________________________ Fax: ______________________________

To Be Released To:

Wakefield Family Medicine, PLLC
131 Meadow Street
Sanbornville, NH 03872
Ph: (603)871-8227 Fax: (603)871-8285

I, the patient or legal representation of patient, understand I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where disclosure has already been made in reliance on my prior authorization. My right to healthcare treatment isn't conditioned on this authorization. I may be charged for the required records. This release will expire 12 months after the date of signature unless otherwise specified.

Patient Signature ________________________________ Date: ______________________

Printed Name of Representative ______________________ Relationship__________________

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## ADULT HEALTH HISTORY

**Patient Name** ______________________________ **Date of Birth**________

**Male**___ **Female**___ **Marital Status** ____ **Date of last physical** _______________

**Specialists:**

**Dentist** _________________________ **Last Visit** _____________________________

**Eye Doctor** ______________________ **Last Visit** _____________________________

**Preferred Pharmacy:** ___________________________________________________

**Current Medications (Include name, dose, and frequency):**

**Allergies to medications, food, or environment / reaction:**

**Medical History: List current medical conditions, chronic illness, and surgeries:**

**Preventative Care (list date of last known:)**

**Colonoscopy** ______________________

**Diabetes Screening** ________________

**Imaging/Lab Studies** _______________

**Mammogram** _____________________

**GYN/Pap Test** ____________________

**Bone Density** _____________________

**Immunizations (Last known):**

**Tetanus or TDAP** ___________

**Pneumovax 23** ____________

**COVID 19** _______________

**Shingles**________________

**Influenza**________________

**Prevnar 13** _____________

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Medical/ Financial Information Disclosure

Date: ____________________

Name: ______________________________________________ DOB______________

I, ____________________________, the undersigned hereby authorize Wakefield Family Medicine, PLLC, its representatives, doctors, and staff to share any and all medical and financial information with the following individual(s).

*If the patient is a minor both parents will automatically have authorization unless court documents are presented specifically stating otherwise.*

_____ At this time I do not wish to authorize anyone other than Parent/ Guardian if a minor.

Name______________________________________ Relationship ________________

Name______________________________________ Relationship ________________

Name______________________________________ Relationship ________________

Name______________________________________ Relationship ________________

Signature of Patient: __________________________________Date_______________

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# Financial Consent

Patient Name: ______________________________ Date: ______________

Email: ______________________________________

Credit Card Information

Type of Card: _____________________________

CC #: ___________________________________

Exp. Date: ____________________ CCV: _________

I consent to having a saved credit card on file that can be used for any co-payments or outstanding balances owed to Wakefield Family Medicine, PLLC.

Patient Signature: ______________________________ Date: ____________

Receipt for any charges will be sent to the above email address.

This CC may be removed or cancelled from use at anytime. Please notify the office.

If balances owed exceeds $300.00, our office will call for consent prior to processing.