Whole Life Health Care
NEW DIRECTIONS IN FAMILY MEDICINE
100 Shattuck Way, Suite 100 · Newington, NH 03801 · Phone 603-431-6677 · Fax 603-610-2232
www.mywholelifehealthcare.com

Patient Registration Form

Patient Information:

Last Name: _____ First Name:_____ Middle Initial:___ DOB: _____

Parent/Guardian (if minor): 1._____ 2._____

Circle One: Patient Gender: Male Female Patient Status: Married Single Divorced Separated Widowed Partner

Address: _____City: _____State: _____ Zip:_____

Home #_____ Cell #_____ Work #_____ (Circle Contact Preference)

Email: _____

Would you like to receive our Monthly Newsletter? Y N

Circle One: Would you like to receive automated appointment reminders via **Phone Call** OR **Text Message**

IN CASE OF EMERGENCY, PLEASE LIST NAME OF LOCAL FRIEND OR RELATIVE WE MAY CONTACT:

Name: _____

Phone: _____ Relationship: _____

Insurance Information:

*****It is the patient's responsibility to know the benefits available under their insurance plan prior to receiving care*****

Health Insurance Company: _____

Member ID: _____ (**include all numbers and letters**)

Subscriber Name (if other than self): _____ Subscriber's DOB: _____

Subscriber Relationship to Patient: Spouse Parent Partner

Under the new Federal Health Care Law of 2011, we have been asked to request the following information from you:

Language (select one)
- ○ **English**
- ○ **Not English**
- ○ **Decline**

Race (please select)
- ○ **American Indian or Alaskan Native**
- ○ **Asian**
- ○ **Black or African American**
- ○ **Native Hawaiian or other Pacific Islander**
- ○ **White**
- ○ **Other**
- ○ **Decline**

Ethnicity (select one)
- ○ **Hispanic or Latino**
- ○ **Non- Hispanic or Latino**
- ○ **Decline**

FOR OFFICE USE ONLY:

Rec'd:	Scheduled:	PCP
Notes:		

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Authorization for Disclosure of Medical Information
No show / Missed appointment policy

PATIENT NAME: _____ DATE OF BIRTH: _____

Due to the Privacy Act please list names of anyone you would like to have access to your medical information. Please understand that without your consent, we will deny any request for information to family members etc. Only the names listed below will be given any information regarding your medical condition.

I hereby authorize Whole Life Health Care, its staff and Providers to disclose my protected health information to the following representative:

NAME: _____ PHONE: _____

RELATION TO PATIENT: _____

NAME: _____ PHONE: _____

RELATION TO PATIENT: _____

This authorization is valid for one year unless specified: _____

You have a right to revoke this authorization at any time by notifying Whole Life Health Care in writing. Whole Life Health Care, its staff and providers may deny access to protected health information to the above representative in certain situations and conditions.

A parent/ guardian must accompany a minor patient on all of the office visits, unless written consent of the parent or legal guardian is received. We may see patients aged 14 and older for family planning related visits without the consent of a parent/ guardian.

In compliance with the Federal Law regarding patient's privacy, we ask you to read the "Notice of Privacy Practices", that is available to view at the office. I understand that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me upon request.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to arrive for their visit on time. If it's necessary to reschedule the appointment, please call us immediately.

A minimum of **24 hours cancellation** notice is required for appointments. If less than a 24 hours cancellation is given, the appointment becomes a "Missed" appointment. If you do not cancel in advance and do not present to the office for your appointment, this will be considered a "No show" appointment. If you incur 3 "No show/ missed" appointments within a one year period you may face discharge from the practice. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.

_____ _____

PATIENT SIGNATURE (Parent/Guardian) DATE

Whole Life Health Care New Patient Registration Form
Name_____ DOB_____ Date_____

Health History Questionnaire

Your answers on this form will help our health care providers better assess your medical needs and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential. *Please bring a copy of your full vaccination list to the first visit.

Main Reason for Establishing Care:	Change in PCP	New Insurance	Re-establishing	Medical Concern
Other Medical Concerns:				
How Did You Hear About Us?				

Preferred Primary Health Care Provider: Please check. (wait times vary per provider)

Amy Coombs		Elisabeth Robinson		Nadine McCall	
Anna Swan		Kimberley Russell		No Preference / First Available	

Current and Past Health Care Providers

Name	Specialty	Contact Information	Status
			Current / Past
			Current / Past
			Current / Past
			Current / Past
			Current / Past
			Current / Past
			Current / Past
			Current / Past

Name_____ DOB_____ Date_____

Pharmacy	Name	Address
Local		
Mail Order		

Allergies/Adverse Reactions

List anything that you are allergic to (medications, food, bee stings, etc.) and how it affects you.

Allergy:	Reaction:	Onset Date:

Current Medications and Supplements. Please list below or provide a printed list.

Drug / Supplement Name:	Strength:	Frequency Taken:

Name_____ DOB_____ Date_____

Medical History

Please Check All That Apply	Current	Past	**Please Check All That Apply**	Current	Past
ADD / ADHD			Fibromyalgia		
Aids/HIV			GI Problems		
Abuse/Domestic Violence			Gout		
Allergies (List in other section)			Headaches		
Anemia			Heart Disease		
Anesthesia Complications			Heart Problems		
Anxiety Disorder			Hepatitis		
Arthritis			High Cholesterol		
Asthma			Hospitalizations		
Autism Spectrum Disorder (ASD)			Hypertension		
Bedwetting			Hyperthyroidism		
Birth Defects or Inherited Disease			Hypothyroidism		
Bladder or Kidney Problems			Impaired Fasting Glucose		
Blood Diseases			Infertility		
Blood Transfusion			Kidney Disease		
Breast Problem(s)			Kidney Stones		
COPD			Liver Disease		
Cancer – Breast			Lung Disease		
Cancer – Lung			Lyme		
Cancer – Other:_____			MRSA Exposure		
Cancer – Ovarian			Meniere's Disease / Vertigo		
Cancer – Prostate			Mental Disorder / Illness		
Chicken Pox			Mononucleosis		
Chronic ear infections			Muscle, Joint or Bone Problems		
Congestive Heart Failure (CHF)			Nasal Polyps		
Constipation			Obesity		
Coronary Artery Disease			Osteoporosis		
Depression			Polyps		
Developmental or Behavioral Disorders			Pre-eclampsia		
Diabetes – Gestational			Psoriasis		
Diabetes – Type 1			Pulmonary Embolism		
Diabetes – Type 2			Reflux/GERD		
Difficulty swallowing			Seizures/Epilepsy		
Diverticulitis			Skin Problems		
Ear or Hearing Problems			Stroke		
Eating Disorder			Thyroid Problems		
Eczema			Tuberculosis		
Endometriosis			Varicosities		
Other: (Please Write In)			Vision or Eye Problems		

Name_____ DOB_____ Date_____

Immunizations:

- **If 18 years or younger, please provide an immunization record from your current provider**
- **If 19 years or older, please list below and/or provide a current immunization record**

Immunization Type:	Date #1	Date #2	Date #3
Flu Shot			
Tdap *(Tetanus and pertussis)*			

Family Health History

Relation	Significant Health Problems and Onset Age	Alive and Healthy	Current Age	Age at Death
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Mother				
Father				
Brother				
Brother				
Sister:				
Sister:				
Other:				
Other:				
Other:				
Other:				

Name_____ DOB_____ Date_____

Social History:

Occupation / Job Title:			Employer / School:			
Lives with:	Husband	Wife	Partner	Family	Alone	Roommate/Housemate
Number of Children:						
Do you have a living will or an advanced directive in place?					Yes	No
Exercise: Please circle and/or add						
Walk	Run	Bike	Cardio	Gym	Weights	
None	Hike	Ski	Mixture	Working on it	Yoga	
Other:						
Diet: Please circle						
Great	OK	Poor	Too many carbs	Too many sweets		
Vegetarian	Vegan	Meat Lover	Paleo	Working on it		
Alcohol: Please circle						
Daily	Social	Weekends	1-2 day	3-4 day	5 day	None
Few per week	Moderate	Heavy	Recovered alcoholic	Occasional	Rare	
Illicit drugs: Please list						
Smoking Status						
Never smoker	Former smoker	Current every day smoker	Current some day smoker			
Tobacco – years of use						
Smoking – how much:						
None	1 PPW	2 PPW	1/4 PPD	1/2 PPD		
1 PPD	1 ½ PPD	2 PPD	3+ PPD			
Caffeine						
Daily	Moderate	Heavy	1-2 day	3-4 day		
4-6 day	6+ day	None	Occasional	Rare		
Sleep						
Great	Good	OK	Poor	Terrible	Snores	Kids wake me often
Stress						
None	Minimal	Moderate	High	Manageable	Out of control	
Dental						
See regularly	See occasionally	Need to see	Can't afford	Dentures	Refuse to see	
Vision						
Good	Wear readers	Wear glasses	Contacts			
Needs glasses	Has eye MD	Needs to see eye MD				
Hearing						
Good	OK	Poor				
Need referral	Has hearing aid(s)	Refuses hearing aid(s)				
Sun Exposure						
Uses SPF	Stay out of the sun	Refuse SPF				
Get some sun	Tans	Uses tanning beds				
Contraception:	Yes	No				

Name_____ DOB_____ Date_____

Surgical History

Surgery	Reason	Year

Overnight Hospitalizations

Hospital	Reason	Year

(Women Only) Obstetric and Gynecological History

Age of first child:							
Age of first menstrual period:							
Date of last menstrual period or age of menopause:							
Current birth control method:							
Date of last mammogram:				Where:			
Date of last Pap smear:				Where:			
Date of last bone density:				Where			
Number of Pregnancies:		Births:		Miscarriages:		Abortions:	

Preventative Medical History

Date of last colonoscopy:		Where:	
Date of last physical?		Where:	
Date of last bloodwork:		Where:	

Name_____ DOB_____ Date_____

Thank you for taking the time to fill out Whole Life Health Care's Health History Form.
This information will be used by the providers during your initial appointment.

When you have completed this form, please return to Whole Life Health Care by:

- Emailing it to dwhitlock@mywholelifehealthcare.com
- Dropping it off at the front desk
- Faxing it to 1-603-610-7713
- Sending it by mail to:

  Whole Life Health Care
  100 Shattuck Way
  Newington, NH 03801

If you have any questions, please call the office at 603-431-6677