

**Primary Care at Memorial Hospital**  
North Conway, NH 03860  
603-356-5472

**PATIENT REGISTRATION**

Patient's Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Last Name First Name Middle Initial

Mailing Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
\_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ M S D W

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**INSURANCE INFORMATION**

Medicare No. \_\_\_\_\_ effective date \_\_\_\_\_ Medicaid No. \_\_\_\_\_ effective date \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Certificate No. \_\_\_\_\_ Grp No. \_\_\_\_\_

Subscriber/DOB: \_\_\_\_\_ / \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Name of person who carries insurance DOB

Office Visit Co-Pay: \$ \_\_\_\_\_ Other family members on plan (with DOB) : \_\_\_\_\_

**MEDICAL INFORMATION**

Allergies: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_ Location of Pharmacy: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN IN THIS OFFICE:** \_\_\_\_\_ Transferring from : \_\_\_\_\_

**All charges are payable at the time of services,** unless previous arrangements have been made. We will bill Medicare, New Hampshire Medicaid, Maine Medicaid, Blue Cross/Blue Shield, Health Source/Cigna, Matthew Thornton, Healthcare Value Management and associated insurances, and certain other insurance companies; you will be responsible for any non-covered balance. For those patients who have insurance companies that we do not bill, we will be happy to provide you with the necessary information for filing with your insurance company, but payment is due at the time of service.

I HEREBY AUTHORIZE PRIMARY CARE AT MEMORIAL HOSPITAL TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT; AND BENEFITS ON MY BEHALF FOR ANY SERVICES FURNISHED BY A PROVIDER OF PRIMARY CARE AT MEMORIAL HOSPITAL BE MADE DIRECTLY TO THEM.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SPECIAL AUTHORIZATION: Drug/Alcohol Abuse, Mental Health Information and/or HIV/Aids.

I acknowledge that the data to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to one or more of the above. My signature below authorizes release of all such information. This authorization will be in effect unless our office receives written notice otherwise.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE PRESENT YOUR INSURANCE CARD AT THE TIME OF REGISTRATION**

Thank you for becoming a part of our practice