

Insight Medical Grp
428 Lafayette STE 101
Hampton, NH 03842



428 Lafayette Rd., Hampton NH. 03842

(603) 395-1724

NEW PATIENT INFORMATION

Please fill the below information as precisely as possible. If a field does not apply to you, note N/A. If you are unsure of the answer, you can approximate the answer or specify that you are not sure.

General information:

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____

DOB: _____ Age: _____ Gender: F M SSN: _____

Ethnicity: Caucasian African-American Asian Hispanic Other _____

Relationship Status: Single _____ yrs Married _____ yrs Serious relationship
 Divorced _____ yrs Widowed _____ yrs

Spouse: _____ Spouse's Main Number: _____

Children? Yes No If yes, how many (specify biologic/step/adoptive children):

Specify Gender/Age: _____

Student? Yes No School name _____

Mailing Address: _____

City, State, Zip: _____

Employer: _____ Job title: _____

Home phone: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

Cell phone: _____ May we leave a message? Yes No

E-mail: _____ May I send e-mail? Yes No

Do you receive text message: Yes No

If yes, specify number: _____ May we leave a text? Yes No

Preferred Method of Contact: _____

How did you first find out about our Services? _____

If referred from a hospital or another physician/clinic, specify name/location/contact info:

If Patient is a Minor:

First/Last Name of Parent/Legal Guardian accompanying minor on this appointment:

Last Name _____ First Name _____

Relations to child:

- Biologic Mother Biologic Father Step-Mother Step-Father Adoptive Mother
 Adoptive Father Guardian

If Legal Guardian is family member other than the above listed, specify relations:

If Legal Guardian is an adoptive parent, specify number of years as guardians: _____ yrs

Address of Parent/Legal Guardian accompanying minor if different than listed above:

Address _____

Are parents divorced? Yes No

If divorced, specify custody arrangement of minor:

Payment/Insurance Information:

Do you have insurance coverage? Yes No

Insurance Company _____

Would you desire receipt of payment from this office? Yes No Doesn't matter

Are you covered by: Medicare Medicaid N/A

First/Last Name of Financially Responsible Party (if different from patient):

Relationship _____

Address (if different than above):

Phone : _____

Medical and referral information:

Primary Care Physician: _____

Address of Office (if known): _____

Office Phone: _____ Office Fax: _____

Pharmacy Name: _____

Pharmacy Address (If not known, specify approximate location/area):

Pharmacy Contact Phone Number: _____

Have you had a previous psychiatrist? Yes No

If yes, specify name of previous psychiatrist/s:

Date of last psychiatric visit with above listed psychiatrist: _____

Emergency contact:

Who should I contact in case of emergency:

Primary Person: _____ Relationship: _____

Phone: _____ Alternative Phone: _____

Secondary Person: _____ Relationship: _____

Phone: _____ Alternative Phone: _____

Signature: _____ Date: _____