Insight Medical Grp
861 Lafayette UNIT 6
Hampton, NH 03842

978) 267-1193

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 _____yrs ☐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: _____