**Compass Health**
835 Central Ave Suite 200 Dover, NH 03820 Phone: (603) 749-0001

## Patient Registration

| Current Patient Information- Please Print | Guarantor Information (to whom statements are sent) |
|---|---|
| Last Name:<br>First Name:<br>Middle Name:<br>Address:<br>City: State:<br>Zip:<br>Home Phone:<br>Work Phone:<br>Cell Phone:<br>Sex: F / M<br>Date of Birth:<br>Social Security No.:<br>Patient Email:<br>Required by government mandate [although you may refuse]:<br>Language:<br>Race:<br>Ethnicity:<br>Marital Status: | Name:<br>Address:<br><br>Relationship to patient:<br>Date of Birth:<br>Phone:<br><br>**Emergency Contact Information**<br>Name:<br>Relationship:<br>Phone:<br>Mobile Phone:<br><br>**Employer Information**<br>Employer:<br>Address:<br><br>Phone: |
| **Other** | **Pharmacy Information** |
| Patient Referred by:<br><br>Primary Care provider:<br><br>Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email | Name:<br><br>Address:<br><br><br>Phone: |
| **Primary Insurance/Policy Holder Information** | **Secondary Insurance/Policy Holder Information** |
| Insurance Plan Name:<br>Address:<br>City: State: Zip:<br>Policy Holder Name:<br>Policy Holder Date of Birth:<br>Employer Name:<br>Patient's relationship to policy holder: | Insurance Plan Name:<br>Address:<br>City: State: Zip:<br>Policy Holder Name:<br>Policy Holder Date of Birth:<br>Employer Name:<br>Patient's relationship to policy holder: |

_____ I hereby assign my insurance benefits to be paid directly to the healthcare provider

_____ I authorize to release medical information required to process my claim

_____ I have read and understand the Financial Policy for Compass Family Health

_____ I authorize to obtain/have access to my medication history

_____ I authorize my provider's office to contact me by mobile phone and email

To the best of my knowledge the above information is complete and accurate.

Signed_____ Date_____