DMC PRIMARY CARE

DMC PRIMARY CARE NEW PATIENT REGISTRATION FORM

Welcome to DMC Primary Care! This form is for patients who wish to transfer their care to DMC Primary Care. Once your form has been completed, a member of our Patient Service Team will reach out to you to schedule an appointment. **Please be sure to also fill out a Release of Medical Records form so that we can access your medical records.** Thank you!

TO ESTABLISH CARE AS A DMC PATIENT:

(1) Complete and submit this new patient registration form.

(2) Complete and submit a Release of Medical Records Form.

(3) Change your PCP to a DMC provider with your insurance ***in their system*** if your plan requires it.

(4) Make an appointment to see a DMC provider.

PATIENT FIRST NAME: _____

PATIENT LAST NAME: _____

PATIENT DATE OF BIRTH (MM/DD/YYYY): ____/____/_____

PATIENT STATE OF RESIDENCE: _____

PATIENT STREET ADDRESS:

_____

PATIENT CITY: _____

PATIENT ZIP CODE: _____

PATIENT/GUARDIAN CELL: **PATIENT/GUARDIAN HOME PHONE:**

_____ _____

PATIENT/GUARDIAN EMAIL ADDRESS: _____

PATIENT GENDER: _____

BEST TIME OF DAY TO REACH YOU (Please select all that apply):

__MORNINGS

__LUNCH TIME (11:30 AM TO 2:00 PM)

__AFTERNOONS

__EARLY EVENINGS (5:00 PM TO 8:00 PM)

PATIENT'S PREVIOUS PROVIDER'S NAME:

_____

PATIENT'S PREVIOUS PROVIDER'S PRACTICE NAME & LOCATION:

_____

APPROXIMATE DATE OF LAST VISIT WITH PROVIDER (MONTH/YEAR): ____/_____

WHY DID YOU/PATIENT LEAVE YOUR PREVIOUS PROVIDER?

_____
_____
_____

PATIENT'S INSURANCE CARRIER:

__AETNA

__ANTHEM/BCBS

__CIGNA/GREAT WEST CIGNA

__COVENTRY/FIRST HEALTH

__FALLON

__HARVARD PILGRIM

__MERITAIN HEALTH

__MEDICARE

__MULTIPLAN/GEHA/PHCS NETWORK

__TUFTS

__UNICARE GIC

__UNITED HEALTH CARE

__WORKER'S COMPENSATION

__OTHER _____

INSURANCE MEMBER ID NUMBER:

_____

<u>IF ESTABLISHING CARE FOR A MINOR</u>: PARENT/GUARDIAN NAME:

_____

<u>IF ESTABLISHING CARE FOR A MINOR</u>: WHAT IS YOUR RELATIONSHIP TO THE MINOR? (MOTHER, FATHER, GUARDIAN, ETC.):

_____

WHICH OFFICE WOULD THE PATIENT PREFER?

__BEDFORD

__CONCORD

__DERRY

__DOVER

__GOFFSTOWN

__LONDONDERRY

__RAYMOND

__WINDHAM

WHICH WOULD THE PATIENT PREFER?

__MALE PROVIDER

__FEMALE PROVIDER

__NO PREFERENCE

HOW DID YOU HEAR ABOUT DMC PRIMARY CARE?

__INTERNET/WEBSITE

__SOCIAL MEDIA

__NEWSPAPER AD

__RADIO COMMERCIAL

__DIRECT MAIL PIECE

__TV COMMERCIAL

__INSURANCE REFERRAL

__HOSPITAL REFERRAL

__PROVIDER OR SPECIALST REFERRAL

__FRIEND/FAMILY MEMBER

__OTHER _____

WHAT IS YOUR RACE AND ETHNICITY (OPTIONAL):

_____

WHAT IS YOUR PREFERRED LANGUAGE IF NOT ENGLISH (OPTIONAL):

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE DMC TO KNOW?

_____
_____
_____
_____
_____
_____