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

Patient Registration

<table>
<tr><th>Current Patient Information- Please Print</th><th>Guarantor Information (to whom statements are sent)</th></tr>
<tr><td rowspan="2">First Name:
Last Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Cell Phone:
Sex: F / M
Date of Birth:
Social Security No:
Patient Email:
Language:
Race:
Ethnicity:</td><td>Name:
Address:
Relationship to patient:
Date of Birth:
Phone:</td></tr>
<tr><td>Emergency Contact Information
Name:
Relationship:
Phone:
Mobile Phone:
Employer Information
Employer:
Address:</td></tr>
<tr><td>Other</td><td>Pharmacy Information</td></tr>
<tr><td>Patient Referred by:
Primary Care provider:
Contact Preference:
Home Phone / Work Phone / Cell Phone / Email</td><td>Name:
Address:</td></tr>
<tr><td>Primary Insurance</td><td></td></tr>
<tr><td>Insurance Plan Name:
Member ID:
Group No:
Policy Holder Name:
Policy Holder Date of Birth:
Patient’s relationship to policyholder:</td><td>Insurance Plan Name:
Member ID:
Group No:
Policy Holder Name:
Policy Holder Date of Birth:
Patient’s relationship to policyholder:</td></tr>
</table>

_____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_____