New Patient Acceptance Request

CROSSROADS FAMILY MEDICINE AND PEDIATRICS

194A Pleasant Street, Suite 101 • Concord, NH 03301 • (603) 856-8828 Fax: (603) 856-8813

Patient Name: _____Date of Birth:_____
(First) (middle initial) (Last)

Gender Identification: _____ Sexual Orientation:_____Title: MR / MISS / MRS / MS

Mailing Address: _____
(street) (town) (zip code)

Home Phone:_____ Cell Phone:_____Other:_____

Email:_____ Would you like to sign up for the Patient Portal? YES NO

Primary Insurance Carrier: _____ Is this a Medicaid Plan? *(circle one)*: YES NO

Secondary Insurance Carrier: _____ Is this a Medicaid Plan? *(circle one)*: YES NO

Currently enrolled in Medicaid? *(circle one)*: YES NO **(we are currently closed to any new medicaid patients)**

If uninsured, is the patient in the process or does the patient intend to apply for Medicaid? *(circle one)*: YES NO

Have you confirmed a provider at Crossroads is in-network for the patient's insurance plan(s)? *(circle one)*: YES NO

****PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S)****
****UPDATE YOUR PCP WITH INSURANCE PRIOR TO YOUR FIRST APPOINTMENT****
(If failed to do so you will be held responsible for any unpaid balances)

Current Diagnoses: _____

Current Medications: _____

I fully acknowledge that providers at this practice do not offer chronic pain (narcotic/opiate) or scheduled benzodiazepine management, and as such, will not prescribe these medications for chronic use. ***(Initial)*: _____**

Reason for change of primary care: _____

Previous Primary care physician/office:_____

This Authorization will be reviewed to determine whether or not the staff and providers at Crossroads Family Medicine and Pediatrics are capable of offering the services needed based on the information provided.

_____ _____
Patient or Legal Parent/Guardian Signature **Date**

_____ _____ _____
Printed Name of Legal Parent/Guardian *(if applicable)* **Relationship to patient** **DOB of Legal Parent/Guardian**

****The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for my balance. I also authorize Crossroads Family Medicine and Pediatrics or my Insurance Company to release any information required to process claims.**

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