Sobriety Centers of New Hampshire

Antrim House
55 Main Street, Antrim, NH 03440 | (603) 808-0185
Sobriety Centers of New Hampshire | Outpatient Program
info@sobrietycentersofnh.com

**Services Interested in:** ☐ Suboxone Treatment ☐ IOP ☐ Vivitrol

**Name (First, MI, Last):** _____ **Social Security #** _____

**Gender:** ☐ Male ☐ Female ☐ Other: _____

**Date of Birth:** _____/_____/_____ **Marital Status:** ☐ Single ☐ Married

**Address:** _____

**City, State, Zip:** _____

**Phone (H):** _____**(C)**_____**(W)**_____

**Email:**_____ **Primary Care Provider:** _____ **Referring Provider:** _____

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages?

☐ Home ☐ Cell ☐ Work

**Emergency Contact:** _____

**Relationship:** _____ **Phone:** _____

Can the above listed contact (with photo identification) pick up prescriptions if you are unavailable? ☐ Yes ☐ No

If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please fill out the Permission to Discuss Form.

| Race | Preferred Language | Ethnicity |
|---|---|---|
| ☐ **White** | ☐ **English** | ☐ **Non-Hispanic or Latino** |
| ☐ **Black or African American** | ☐ **Other:** _____ | ☐ **Hispanic or Latino** |
| ☐ **Asian** | | ☐ **Other:** _____ |
| ☐ **American Indian or Alaska Native** | | |
| ☐ **Native Hawaiian or other Pacific Islander** | | |
| ☐ **Other:** _____ | | |

| ***Primary Insurance:*** | ***Secondary Insurance:*** |
|---|---|
| | |

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| | |
|---|---|
| **Insurer ID#:** | **Insurer ID#:** |
| **Group #:** | **Group #:** |
| **Claims Address:** | **Claims Address:** |
| **Subscriber:** | **Subscriber:** |
| **Subscriber's Date of Birth:** | **Subscriber's Date of Birth:** |
| **Relationship to Patient:** ☐ **Self** ☐ **Spouse** ☐ **Other** | **Relationship to Patient:** ☐ **Self** ☐ **Spouse** ☐ **Other** |

The above information is thorough and accurate to the best of my knowledge. Any changes to the above information will be communicated with the office.

I consent to evaluation and treatment by any provider at Antrim House. I hereby authorize release of medical information that is necessary for my further treatment.

_____ _____

Patient Signature (or Guardian) Date