



New London Hospital
Dartmouth-Hitchcock

Newport Health Center
11 John Stark Highway
Newport, NH 03773
(603) 863-4100

Dear Patient,

Thank you for choosing the Newport Health Center for your medical needs. Our goal is to provide you with quality care every time.

To ensure that your Newport Health Center team has all of your medical information, we ask that you complete the highlighted areas and sign the attached Authorization for Release of Medical Records so we may request your records from your previous medical provider. Please note that if you do not fill in the entire Medical Record release form it will hold up the request of your records and delay your first appointment. Your records may take up to 30 days to receive; you will be contacted once your records have been processed.

Also, please complete the Patient Information and Patient History Forms. You may return all forms by mail or drop them off at the Newport Health Center Medical Records Department.

The following providers are available to see new patients in the areas of infancy to elderly care. **Please select a provider preference:**

- Benjamin Holobowicz Jr MPAS, PA-C
- Amanda Dostaler DO
- Melissa Nelson APRN
- Shannon Schachtner APRN
- Rebecca Lozman-Oxman DNP, CPNP, MPH (Pediatric only)

If you do not have a provider preference please select: Male / Female

Your provider preference will be taken into consideration by the Medical Director who reviews all new patient requests.

Upon completion of your acceptance as a new patient at Newport Health Center, you will receive a call to set up your “establish care visit” this is typically a well visit or yearly exam.

If you have any questions, please contact us at 603-863-4100.

The Newport Health Center team looks forward to taking care of your healthcare needs.

PLEASE RETURN THIS FORM WITH YOUR PACKET

PATIENT INFORMATION

Name: _____
Last First MI

Phone: _____
Home Work Cell

Mailing address: _____ Street Address _____

Sex: M F DOB: ____/____/____ SSN: ____-____-____

Marital Status: M S D W Sep

Employed: FT PT Self Ret Military Not employed

Spouse's Name: _____ Spouse's Phone: _____

Emergency Contact (other than spouse): _____
 Phone: _____ Relationship: _____

Employer: _____ Student: FT PT

GUARANTOR INFORMATION

Same as above: if patient is over 18 years of age

Name: _____
Last First MI

Phone: _____
Home Work Cell

Mailing address: _____ Street Address _____

Sex: M F DOB: ____/____/____ SSN: ____-____-____

Employer: _____

INSURANCE INFORMATION

Insurance Company: _____

Subscriber Name: _____

Certificate #: _____ Group Name / Number: _____

Please present insurance card(s) to the front desk. Any co-payment is due at time of service.



Patient's Name:		M	F
Physical Address:		Date of Birth:	
Mailing Address:		SS # (optional):	
Home Phone #:		Cell Phone #:	
1 st Legal Parent/Guardian:		Relationship:	
Physical Address:		Date of Birth:	
Mailing Address:		SS # (optional):	
Home Phone #:			
Cell Phone#			
Work Phone #:		Place of employment:	
2 nd Legal Parent/Guardian:		Relationship:	
Physical Address:		Date of Birth:	
Mailing Address:		SS # (optional):	
Home Phone #:		Cell Phone #:	
Work Phone #:		Place of employment:	
Insurance Company:		Certificate/ID #:	
Subscriber/Guarantor Name:		Group #:	
Patient Sibling's Names	Date of Birth	Patient Sibling's Names	Date of Birth
Are there any other person's living in the household? (step-parents/siblings, significant other, foster children, etc.):			
NOTES: (custody arrangements, adoption, language or communication barriers, etc.)			



HEALTH HISTORY

Name: _____ Date: _____

Age: _____ Birthdate: _____ Date of Last Physical Exam: _____

What is the Reason for Today's Visit? _____

SYMPTOMS: CHECK (X) BOX FOR SYMPTOMS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR		
GENERAL	GENITAL/URINARY	WOMEN ONLY
<input type="checkbox"/> Chills	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Bleeding Between Periods
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Lack of Bladder Control	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Fainting	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Extreme Menstrual Pain
<input type="checkbox"/> Fever	EYE, EAR, NOSE & THROAT	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Headache	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Painful Intercourse
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Difficulty Swallowing	Date of Last Period: _____
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Double Vision	Date of Last Pap Smear: _____
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Earache	Date of Last Mammogram: _____
<input type="checkbox"/> Numbness	<input type="checkbox"/> Ear Discharge	Number of Children: _____
<input type="checkbox"/> Sweats	<input type="checkbox"/> Hay Fever	Are You Pregnant? _____
	<input type="checkbox"/> Hoarseness	MEN ONLY
GASTROINTESTINAL	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Erection Difficulties
<input type="checkbox"/> Bloating	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Lump in Testicles
<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Penis Discharge
<input type="checkbox"/> Constipation	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Sore on Penis
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Vision - Flashes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Vision - Halos	CARDIOVASCULAR
<input type="checkbox"/> Excessive Thirst	SKIN	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Gas	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hives	<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Itching	<input type="checkbox"/> Low Pressure
<input type="checkbox"/> Nausea	<input type="checkbox"/> Change in Moles	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Rash	<input type="checkbox"/> Rapid Heart beat
<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Scars	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sores that Won't Heal	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Vomiting Blood		
MUSCLE/JOINT/BONE	ALLERGIES: Medications/Substances	MEDICATIONS YOU CURRENTLY TAKE
Pain, Weakness, Numbness in:		
<input type="checkbox"/> Arms <input type="checkbox"/> Hips		
<input type="checkbox"/> Back <input type="checkbox"/> Legs		
<input type="checkbox"/> Feet <input type="checkbox"/> Neck		
<input type="checkbox"/> Hands <input type="checkbox"/> Shoulders		
Pharmacy Name		
Pharmacy Name #		
HEALTH HABITS	OCCUPATIONAL CONCERNS	SERIOUS ILLNESS/INJURY
How often do you use these Substances:	Check if your work exposes you to:	DATE OUTCOME
Alcohol: _____	Stress: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tobacco: _____	Hazardous Substances: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caffeine: _____	Heavy Lifting: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Drugs: _____	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: _____	Your Occupation: _____	





Name: _____ DOB: _____

CONDITONS: CHECK (X) BOX FOR CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR

<input type="checkbox"/> AIDS	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Polio
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Gout	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hernia	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Measles	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Vaginal Disease
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mumps	

Check (X) If your blood relatives had any of the following:

FAMILY HISTORY					Disease	Relationship to You
Relation	Age	State of Health	Age at Death	Cause of Death		
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers:					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters:					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Name of Hospital	Reason & Outcome	Year of Birth	Gender	Complications
				M/F	
				M/F	
				M/F	
				M/F	
				M/F	
				M/F	

Have you ever had a Blood Transfusion? Yes No If Yes, Approximate Date(s) ? _____



**PERMISSION TO SEND HEALTH INFORMATION TO A
DARTMOUTH-HITCHCOCK AFFILIATED COVERED ENTITY**

Use this form when you want a health care provider to send your medical records to D-HH.

PATIENT INFORMATION

Patient Name: _____
 Date of Birth: _____ Phone Number: () _____
 Address: _____
 City: _____ State: _____ Zip: _____

SENDER

I authorize:

Name of Provider: _____
 Street Address: _____ Fax Number: () _____
 City: _____ State: _____ Zip: _____

RECIPIENT

to share (disclose) my health information with Dartmouth-Hitchcock Health at the following location(s):

q Alice Peck Day Health Information Services Ph: (603) 448-7433 Fax: (603) 640-1984	q Cheshire Medical Center HIM Dept. Ph: (603) 354-5477 Fax: (603) 354-6530	q Concord DH Medical Release Dept. Ph: (603) 229-5145 Fax: (603) 229-5146	q DHMC Release of Information Ph: (603) 650-7110 Fax: (603) 727-7869	q Manchester DH Health Information Services Ph: (603) 695-2820 Fax: (603) 676-4290	q Nashua DH Health Information Services Ph: (603) 577-4037 Fax: (603) 577-4039	q Newport Health Center Release of Information Ph: (603) 863-2855 Fax: (603) 863-3585
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If mailing my information, please return requested records to the following department/section or provider:

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Department Reports | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Inpatient Progress Notes | <input type="checkbox"/> Laboratory/Pathology reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Outpatient Visit (Office) Notes | <input type="checkbox"/> School Physical Forms | <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> X-Ray Films |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Records from a Specific Provider: _____ | |

For the following purpose: _____

SENSITIVE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. **I understand and agree that this information will be sent to Dartmouth-Hitchcock Health to include the location noted above UNLESS I place my initials in the applicable space below, next to the type of records:**

- | | |
|---------------------------------------|--|
| _____ Mental health treatment records | _____ Sexually Transmitted Disease (STD) treatment records |
| _____ Genetic testing | _____ Alcohol/drug abuse treatment records |
| _____ HIV/AIDS test results | |

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: _____ (date). I or my Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: Dartmouth-Hitchcock Health and _____ **[SENDER NAME]** will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. My sending healthcare provider may require fees to process my request.

SIGNATURE

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

INSTRUCTIONS:

How to use "Permission to Send Health Information to Dartmouth-Hitchcock" form

This form should be used when you want your health care provider to send your medical records to Dartmouth-Hitchcock. If you want D-H to send to your medical records to another health care provider or other third party, please use the "Permission to Share Patient Health Information" authorization form. You can find the form at: http://www.dartmouth-hitchcock.org/medical-information/medical_records_release_forms.html

Please note that the sending health care provider's office may have additional requirements for authorizing records to be released to Dartmouth-Hitchcock.

PATIENT INFORMATION

Complete each box as indicated with the following information:

- Patient's name (please print clearly)
- Patient's date of birth
- Patient/Personal Representative's phone number
- Patient's mailing address, including City, State, and Zip Code

SENDER

Please fill in which health care provider you are authorizing to send your medical records to Dartmouth-Hitchcock:

- Provider's name or Provider's office/practice name
- Mailing address of the health care provider, including Street, City, State, and Zip Code
- Fax number of the health care provider's office

RECIPIENT

Check the Dartmouth-Hitchcock Health location where you would like your information sent. You may check multiple locations. If you would like your records to be sent to a specific health care provider at Dartmouth-Hitchcock Health, please fill in the appropriate provider's name or department/section (e.g., Pediatrics, Orthopedics, etc.).

HEALTH INFORMATION TO BE SHARED

Fill in the date range that applies to the health information you are requesting to be sent to Dartmouth-Hitchcock.

Check the box(es) that describe the information you are requesting to be sent to Dartmouth-Hitchcock.

- For multi-provider group practices, you can indicate you want to have records sent from only a specific provider by checking the "Records from a specific provider" box and filling in the relevant provider's name.

Fill in a description of the purpose of the requested records. Examples: Transfer to new provider, facilitate treatment, summarize treatment, etc. This section must be completed in order for the form to be valid.

SENSITIVE HEALTH INFORMATION

Depending on the state where your health care provider practices, additional laws and/or signature requirements may apply to releases of "sensitive" categories of health information. If you do not place your initials in the spaces provided, the health care provider may release such sensitive information as necessary to fulfill your request.

DURATION & REVOCATION

Your authorization will remain valid for one year from the date of your signature, unless you specify a different date in the space provided. You have the right to revoke your permission at any time. Note that your revocation will not apply to any previously released information. Please revoke by following the directions in the health care provider's Notice of Privacy Practices, or call the provider's office where your records are located.

ADDITIONAL INFORMATION

Please read this section on the form. Please fill in the blank space with the sending health care provider's name.

SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign the form in addition to their parent/legal guardian, depending on the type of care received. This will be determined by the sending health care provider's protocol.

If you are not the patient, describe your relationship and legal authority to sign on behalf of the patient. In some cases, you may be required to provide legal paperwork verifying your legal authority (e.g., court-appointed guardian, power of attorney for health care). Check with the sending health care provider's office regarding these requirements.

Alice Peck Day Health Information Services 10 Alice Peck Day Dr. Lebanon NH 03766 Ph: (603) 448-7433 Fax: (603) 640-1984	Cheshire Medical Center HIM Dept. 590 Court St. Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 354-6530	Concord DH Medical Release Dept. 253 Pleasant St. Concord, NH 03301 Ph: (603) 229-5145 Fax: (603) 229-5146	DHMC Release of Information One Medical Center Dr. Lebanon, NH 03756 Ph: (603) 550-7189 Fax: (603) 727-7889	Manchester DH Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 676-4290	Nashua DH Health Information Services 2300 Southwood Dr. Nashua, NH 03063 Ph: (603) 577-4037 Fax: (603) 577-4039	New London Hospital Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051
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Dartmouth-Hitchcock Health

Designation of Personal Representative

NAME: _____

DOB: _____

Two identifiers needed

MRN: _____

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patients' Bill of Rights and the federal HIPAA Privacy Rule, as indicated below:

Name _____ Relationship _____

Address _____ Phone Number _____

Verbal Conversations:

I permit the staff at Dartmouth-Hitchcock (comprised of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinics); Cheshire Medical Center; Alice Peck Day Memorial Hospital (APD); and New London Hospital, including Newport Health Center (NLH); to discuss my protected health information, in person or by telephone, with the person named above. This includes the ability to make, cancel, or reschedule appointments on my behalf and assist me in making payments or inquiring about my billing account.

Other:

In addition, I grant my Personal Representative the following:

- Proxy access to my "myD-H" patient portal account;
- The ability to request or receive paper or electronic copies of my medical records
- The ability to authorize use or disclosure of my protected health information;
- If my Personal Representative is an employee of Dartmouth-Hitchcock, Cheshire Medical Center, or APD, the ability to access my entire medical record electronically.

I understand and acknowledge that the protected health information I am authorizing Dartmouth-Hitchcock, Cheshire Medical Center, APD, and NLH to share with my Personal Representative may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information.

I understand and acknowledge that this designation applies to all clinical areas of Dartmouth-Hitchcock, Cheshire Medical Center, APD and NLH.

This authorization shall remain in effect until I send a written request to revoke to Dartmouth-Hitchcock, Cheshire Medical Center, APD, or NLH Health Information Services. Submitting a new form will revoke an existing form.

Patient's Printed Name

Date

Signature of Patient or Legal Representative

Legal Representative's Name (if applicable)

"Dartmouth-Hitchcock Health (D-HH)" is the corporate parent of the covered entities listed below, each of which is an individual corporate entity legally separate and distinct from Dartmouth-Hitchcock Health. Member organizations include: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and D-H Clinic, operating jointly as "Dartmouth-Hitchcock," Mt. Ascutney Hospital and Health Center, New London Hospital, and the Visiting Nurses and Hospice for VT and NH. The D-H ACE comprises only of D-HH members who are currently using a single, integrated electronic medical record system, sometimes referred to as "eD-H."

