New London Medical Group
273 County Rd, New London, NH 03257
(603)526-5544

Dear Patient,

Thank you for choosing New London Medical Group for your medical needs. Our goal is to provide you with quality care every time.

To ensure that your New London Medical Group 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 New London Hospital Medical Records Department.

The following providers are available to see new patients in the areas of infancy to elderly care.
_____Michael Simpson, APRN
_____Brooke Latulippe, APRN
_____Kathleen Higgins, APRN
_____Brian Frenkiewich DO
_____Griffin Manning, APRN
_____Rebecca Wood MD (adult only)

If you have a provider preference please select: Male/Female

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

If you have any questions, please contact us at (603)526-5544
The New London Medical Group team looks forward to taking care of your healthcare needs.

PLEASE RETURN THIS FORM WITH YOUR PACKET

New London Hospital
Dartmouth-Hitchcock

PATIENT INFORMATION

Name: _____ _____ ____
Last First MI

Phone: _____ _____ _____
Home Work Cell

Mailing Address: _____ Physical 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: _____ Physical 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.

New London Hospital
Dartmouth-Hitchcock

Pediatric Demographics

Patient's Name:	M F
Physical Address:	Date of Birth:
Mailing Address:	SS # *(optional):*
Home Phone #:	Cell Phone #:
1st Legal Parent/Guardian:	Relationship:
Physical Address:	Date of Birth:
Mailing Address:	SS # (*optional*):
Home Phone #:	
Cell Phone#	
Work Phone #:	Place of employment:

2nd 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.)

New London Hospital
Dartmouth-Hitchcock

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
☐ Chills	☐ Blood in Urine	☐ Abnormal Pap Smear
☐ Depression	☐ Frequent Urination	☐ Bleeding Between Periods
☐ Dizziness	☐ Lack of Bladder Control	☐ Breast Lump
☐ Fainting	☐ Painful Urination	☐ Extreme Menstrual Pain
☐ Fever	**EYE, EAR, NOSE & THROAT**	☐ Hot Flashes
☐ Forgetfulness	☐ Bleeding Gums	☐ Nipple Discharge
☐ Headache	☐ Blurred Vision	☐ Painful Intercourse
☐ Loss of Sleep	☐ Crossed Eyes	☐ Vaginal Discharge
☐ Loss of Weight	☐ Difficulty Swallowing	Date of Last Period:
☐ Weight Gain	☐ Double Vision	Date of Last Pap Smear:
☐ Nervousness	☐ Earache	Date of Last Mammogram:
☐ Numbness	☐ Ear Discharge	Number of Children:
☐ Sweats	☐ Hay Fever	Are You Pregnant?
GASTROINTESTINAL	☐ Hoarseness	**MEN ONLY**
☐ Poor Appetite	☐ Loss of Hearing	☐ Breast Lump
☐ Bloating	☐ Nosebleeds	☐ Erection Difficulties
☐ Bowel Changes	☐ Persistent Cough	☐ Lump in Testicles
☐ Constipation	☐ Ringing in Ears	☐ Penis Discharge
☐ Diarrhea	☐ Sinus Problems	☐ Sore on Penis
☐ Excessive Hunger	☐ Vision - Flashes	☐ Other
☐ Excessive Thirst	☐ Vision - Halos	**CARDIOVASCULAR**
☐ Gas	**SKIN**	☐ Chest Pain
☐ Hemorrhoids	☐ Bruise Easily	☐ High Blood Pressure
☐ Indigestion	☐ Hives	☐ Irregular Heartbeat
☐ Nausea	☐ Itching	☐ Low Pressure
☐ Rectal Bleeding	☐ Change in Moles	☐ Poor Circulation
☐ Stomach Pain	☐ Rash	☐ Rapid Heart beat
☐ Vomiting	☐ Scars	☐ Swelling of Ankles
☐ Vomiting Blood	☐ Sores that Won't Heal	☐ Varicose Veins

MUSCLE/JOINT/BONE	ALLERGIES: Medications/Substances	MEDICATIONS YOU CURRENTLY TAKE
Pain, Weakness, Numbness in:		
☐ Arms ☐ Hips		
☐ Back ☐ Legs		
☐ Feet ☐ Neck		
☐ Hands ☐ 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: ☐ Yes ☐ No			
Tobacco:	Hazardous Substances: ☐ Yes ☐ No			
Caffeine:	Heavy Lifting: ☐ Yes ☐ No			
Drugs:	Other: ☐ Yes ☐ No			
Other:	Your Occupation:			

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New London Hospital
Dartmouth-Hitchcock

HEALTH HISTORY (cont'd)

Name: **DOB:**

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

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

FAMILY HISTORY

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

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

HOSPITALIZATIONS

Year	Name of Hospital	Reason & Outcome

PREGNANCY HISTORY

Year of Birth	Gender	Complications
	M/F	
	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) ?

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Dartmouth-Hitchcock Health

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):

❑ **Alice Peck Day**	❑ **Cheshire Medical Center**	❑ **Concord DH**	❑ **DHMC**	❑ **Manchester DH**	❑ **Nashua DH**	❑ **New London Hospital**
Health Information Services Ph: (603) 448-7433 Fax: (603) 640-1984	HIM Dept. Ph: (603) 354-5477 Fax: (603) 354-6530	Medical Release Dept. Ph: (603) 229-5145 Fax: (603) 229-5146	Release of Information Ph: (603) 650-7110 Fax: (603) 727-7869	Health Information Services Ph: (603) 695-2820 Fax: (603) 676-4290	Health Information Services Ph: (603) 577-4037 Fax: (603) 577-4039	Release of Information Ph: (603) 526-5247 Fax: (603) 526-5051

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 _____

☐ Discharge Summary ☐ Emergency Department Reports ☐ Immunizations

☐ Inpatient Progress Notes ☐ Laboratory/Pathology reports ☐ Operative Reports

☐ Outpatient Visit (Office) Notes ☐ School Physical Forms ☐ X-Ray Reports ☐ X-Ray Films

☐ Other _____ ☐ 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	**Cheshire Medical Center**	**Concord DH**	**DHMC**	**Manchester DH**	**Nashua DH**	**New London Hospital**
Health Information Services 10 Alice Peck Day Dr. Lebanon NH 03766 Ph: (603) 448-7433 Fax: (603) 640-1984	HIM Dept. 590 Court St. Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 354-6530	Medical Release Dept. 253 Pleasant St. Concord, NH 03301 Ph: (603) 229-5145 Fax: (603) 229-5146	Release of Information One Medical Center Dr. Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869	Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 676-4290	Health Information Services 2300 Southwood Dr. Nashua, NH 03063 Ph: (603) 577-4037 Fax: (603) 577-4039	Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051

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."

Health Information Services Approval: 2/14/2020 EFMC Approval: 7/11/2019 Scan to: Designated Personal Representative

Name: DOB:

Date	Script Name	Printed Name	Signature	Staff Initials