Dartmouth Health

New London Hospital
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**:

____ Michael Kricko DO
____ Benjamin Holobowicz Jr MPAS, PA-C
____ Amanda Dostaler DO
____ Melissa Nelson APRN
____ Shannon Schachtner APRN
____ Rebeccca 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**

Dartmouth Health

## 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.*

Dartmouth Health

# 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.)

Dartmouth Health

# 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: | | | |
| | | | | |



*NHC1068*

Dartmouth Health

# 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) ?**



*NHC1068*

# PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH HEALTH

**Use this form when you want your records sent to Dartmouth Health from another provider/facility.**

| PATIENT INFORMATION | SENDER |
|---|---|
| Patient Name: _____ | **I authorize:** |
| Date of Birth: _____ Ph: _____ | Name of Provider/Facility: _____ |
| Address: _____ | _____ |
| City: _____ State: _____ Zip: _____ | Address: _____ City: _____ |
| | State: _____ Zip: _____ Fax: (_____) _____ |

**RECIPIENT:**

**To share (disclose) my health information with Dartmouth Health, please send my records to the following Dartmouth Health member location:**

| | | | |
|---|---|---|---|
| ❑ **Alice Peck Day**<br>Health Information Services<br>10 Alice Peck Day Drive<br>Lebanon NH 03766<br>Ph: (603) 308-0026<br>Fax: (603) 640-1970<br>Email: medicalrecords@apdmh.org | ❑ **Cheshire Medical Center**<br>HIM Department<br>590 Court Street<br>Keene, NH 03431<br>Ph: (603) 354-547<br>Fax: (603) 676-4253<br>Email: cmcroi@cheshire-med.com | ❑ **Dartmouth Hitchcock Medical Center**<br>Release of Information<br>1 Medical Center Drive<br>Lebanon, NH 03756<br>Ph: (603) 650-7110<br>Fax: (603) 727-7869<br>Email:<br>Lebanon.Release.of.Information@ hitchcock.org | ❑ **Hanover Psychiatry**<br>23 S. Main St., Suite 2B<br>Hanover, NH 03755<br>Ph: (603) 277-9110<br>Fax: (603) 277-9154 |
| ❑ **Manchester, Nashua & Concord - DH**<br>Health Information Services<br>100 Hitchcock Way<br>Manchester, NH 03104<br>Ph: (603) 695-2820<br>Fax: (603) 727-7828<br>Email: DH-ROI@hitchcock.org | ❑ **New London Hospital**<br>Release of Information<br>273 County Road<br>New London, NH 03257<br>Ph: (603) 526-5247<br>Fax: (603) 526-5051 | ❑ **Newport Health Center**<br>Release of Information<br>11 John Stark Highway<br>Newport, NH 03773<br>Ph: (603) 865-2855<br>Fax: (603) 863-3585 | ❑ **Visiting Nurse and Hospice for VT/NH**<br>Release of Information<br>1 Medical Center Drive<br>Lebanon, NH 03756<br>Ph: (603) 650-7110<br>Fax: (603) 727-7869<br>Email:<br>Lebanon.Release.of.Information@ hitchcock.org |

**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
- ❑ Inpatient Progress Notes
- ❑ Outpatient Visit (Office) Notes
- ❑ Other: _____
- ❑ Emergency Department Reports
- ❑ Laboratory/Pathology Reports
- ❑ School Physical Forms
- ❑ Records from a Specific Provider: _____
- ❑ Immunizations
- ❑ Operative Reports
- ❑ X-Ray Reports
- ❑ X-Ray Films

**For the following purpose:** _____

**SENSITIVITE 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 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
- _____ Genetic testing
- _____ HIV/AIDS test results
- _____ Sexually transmitted disease (STD) treatment records
- _____ Alcohol/drug abuse treatment records

**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 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 of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Description of Personal Representative's Authority

# INSTRUCTIONS:
# How to use the "Permission to Send Health Information to Dartmouth Health" form.

*This form should be used when you want your healthcare provider to send your medical records to Dartmouth Health. If you want Dartmouth Health to send your medical records to another healthcare provider or other third party, please use the "Permission to Share Patient Health Information" authorization form. You can find the form at: https://www.dartmouth-hitchcock.org/patients-visitors/medical-records-release-forms.*

**Please note that sending a healthcare provider's office notes may have additional requirements for authorizing records to be released to Dartmouth Health.**

## 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 healthcare provider/facility you are authorizing to send your medical records to Dartmouth-Hitchcock including:

- Provider/facility name
- Mailing address including Street, City, State, and Zip Code
- Fax number for the healthcare provider/facility

## RECIPIENT

Check the Dartmouth 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 healthcare provider at Dartmouth Health, please fill in the appropriate provider's name or department/section (e.g., Pediatrics, Orthopaedics, 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 Health.

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

- 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 healthcare provider's office regarding these requirements.

| | | | |
|---|---|---|---|
| ❑ **Alice Peck Day**<br>Health Information Services<br>10 Alice Peck Day Drive<br>Lebanon NH 03766<br>Ph: (603) 308-0026<br>Fax: (603) 640-1970<br>Email: medicalrecords@apdmh.org | ❑ **Cheshire Medical Center**<br>HIM Department<br>590 Court Street<br>Keene, NH 03431<br>Ph: (603) 354-547<br>Fax: (603) 676-4253<br>Email: cmcroi@cheshire-med.com | ❑ **Dartmouth Hitchcock Medical Center**<br>Release of Information<br>1 Medical Center Drive<br>Lebanon, NH 03756<br>Ph: (603) 650-7110<br>Fax: (603) 727-7869<br>Email:<br>Lebanon.Release.of.Information@ hitchcock.org | ❑ **Hanover Psychiatry**<br>23 S. Main St., Suite 2B<br>Hanover, NH 03755<br>Ph: (603) 277-9110<br>Fax: (603) 277-9154 |
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Dartmouth Health

**Designation of Personal Representative**

MRN:

NAME: Two identifiers needed

DOB:

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

Health Information Services Approval: 11/30/2020 EFMC Approval: 12/10/2020 Scan to: Personal Representative