Dartmouth Health

Newport Health Center

Dear Patient,

Thank you for choosing the Newport Health Center (NHC) for your medical needs. Our goal is to provide you with quality care every time. It is important to note that NHC is accepting new patients from all towns within our service area only. Service area includes: Andover, Bradford, Croydon, Danbury, Goshen, Grantham, Lempster, New London, Newbury, Newport, Springfield, Sunapee, Sutton, Unity, Washington, and Wilmot.

To ensure that the Newport Health Center team has all of your medical information, we ask that you complete 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 the Medical Record Release form is not filled out completely, it may 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.

If you have a provider preference, please select: __ Male __ Female

Your provider preference will be taken into consideration by the Ambulatory Practice Group 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 first appointment.

If you have any questions, please contact us at 603-863-4100. We look forward to taking care of your healthcare needs.

PLEASE RETURN THIS FORM WITH YOUR PACKET

New London Hospital
Newport Health Center
11 John Stark Highway, Newport, NH 03773

Tel (603) 863-4100
Fax (603) 863-3585

Dartmouth Health

New London Hospital
Newport Health Center

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

Employer: _____ Student: ☐ FT ☐ PT

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

Emergency Contact (other than spouse): _____

Phone: _____ Relationship: _____

GUARANTOR INFORMTION

☐ *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: _____

Subscribers Name: _____

Certificate #: _____ Group Name/Number: _____

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

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

Dartmouth Health

HEALTH HISTORY (cont'd)

Name: **DOB:**

CONDITIONS: 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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PEDIATRIC DEMOGRAPHS

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 | New London Hospital

Pediatric Form

Please complete this form if the establishing patient is under 18 years of age

Child's Name: _____
Preferred Name: _____
Date of Birth: _____

Previous Medical History: ☐ **None** (asthma, recurrent UTI, seizure, anemia, depression, ear infections, murmur, other)
_____
_____
_____

Surgical History: ☐ **None** ☐ **Yes** (type of surgery and when)
_____

Hospitalizations: ☐ **None** ☐ **Yes** (what condition and when)
_____
_____

Allergic Reactions: ☐ **None** (to what and when)
Allergy to: _____ Date of Reaction: _____
Allergy to: _____ Date of Reaction: _____
What happened: ☐ Rash ☐ Difficulty Breathing ☐ Vomiting
☐ Facial Swelling ☐ Other: _____

Medication History: ☐ **None** (list on back if needed)
Daily Medications:
What: _____ Dose: _____
What: _____ Dose: _____
As Needed Medications:
What: _____ Dose: _____
What: _____ Dose: _____

Are Immunizations Up to Date: ☐ **Yes** ☐ **No**
(Please provide our office with a copy of the records)

Developmental Milestones:
Rolling Over Age: _____ Walking Age: _____
Sitting Up Age: _____ Talking Age: _____

School History: ☐ **None**
Name of School: _____
Current Grade Level: _____
Average Grades This School Year: ☐ A ☐ B ☐ C ☐ D ☐ F
School Problems: _____
Seen by Speech Therapist, Psychologist, or Special Teachers:
_____

Family History: (provide history of child's: mother, father, siblings, grandmother, grandfather, uncle, aunt)

Asthma	☐ No	☐ Yes	Who: _____
Anemia	☐ No	☐ Yes	Who: _____
Cancer (*before 55)*	☐ No	☐ Yes	Who: _____
Heart Disease (*before 55)*	☐ No	☐ Yes	Who: _____
Stroke	☐ No	☐ Yes	Who: _____
Diabetes	☐ No	☐ Yes	Who: _____
Epilepsy or Seizures	☐ No	☐ Yes	Who: _____
Substance Abuse	☐ No	☐ Yes	Who: _____
Mental Illness	☐ No	☐ Yes	Who: _____
Developmental Disorder	☐ No	☐ Yes	Who: _____

Birth History:
Birth Weight: _____lb _____oz
Birth Length: _____ in _____cm
Was the baby circumcised? ☐ Yes ☐ No
Was the baby born at term? ☐ Yes ☐ No; Born at _____ weeks
Was the delivery ☐ Vaginal ☐ Cesarean? If cesarean, why?
_____
_____
Were there any complications before birth or after birth?
_____
_____
Was a NICU stay required? ☐ Yes ☐ No
Explain: _____
Normal newborn screen at birth? ☐ Yes ☐ No
Normal hearing screen at birth? ☐ Yes ☐ No
During pregnancy, did the mother:
Use tobacco? ☐ Yes ☐ No Drink Alcohol? ☐ Yes ☐ No
Use drugs or medication? ☐ Yes ☐ No
What: _____ When: _____

Travel History
Has your child traveled outside the United States in the last 3 months? ☐ No ☐ Yes Where: _____

Social History:
Pets in the home? ☐ Yes ☐ No
If so, what kind and how many? _____
Pool at home**?** ☐ Yes ☐ No
Guns at home? ☐ No ☐ Yes; Are they secured? ☐ Yes ☐ No
Smoke exposure? ☐ Yes ☐ No
Do they attend daycare? ☐ No ☐ Yes; How many days? _____
Who lives in the home? ☐ Mom ☐ Dad ☐ Stepmother
☐ Stepfather ☐ Grandmother ☐ Grandfather
☐ Other: _____
How many siblings? _____ Siblings Ages: _____
Are there any custody concerns? ☐ Yes (explain) ☐ No
_____
_____

Let us get to know you:
How long has your family lived in this area? _____
Where did you live before coming to this area? _____
Is there anything you would like us to know about your child?
_____
_____
_____

Dartmouth Health **Designation of Personal Representative**	MRN: NAME: DOB: Two identifiers needed or Patient label

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 Health comprised of: Dartmouth Hitchcock Medical Center (DHMC) and Dartmouth Hitchcock Clinics (DHC); Cheshire Medical Center; Alice Peck Day Memorial Hospital (APD); New London Hospital, including Newport Health Center (NLH); Hanover Psychiatry (HP), and Visiting Nurse and Hospice for VT and NH (VNH), 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 "myDH" patient portal account;
- ❑ The ability to request or receive paper or electronic copies of my medical records;
- ❑ The ability to authorize the use or disclosure of my protected health information;
- ❑ If my Personal Representative is an employee of DHMC, DHC, 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 Health: DHMC, DHC, Cheshire Medical Center, APD, NLH, HP, or VNH 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 Health.

This authorization shall remain in effect until I send a written request to revoke to Dartmouth Health. 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 "eDH."