Welcome to APD

Dear Patient,

Thank you for selecting the Alice Peck Day Memorial Hospital for your health care needs. Attached are forms that include a personal health history, a medication list, and a release of information. To help meet your health care needs, please complete these forms and return them to us via fax 603-442-5983 or by e-mail: patientservices@apdmh.org.

Your history and your records from your previous health care provider(s) supply us with important information about your health, so please be sure to fill out the HIPAA Compliant Authorization for Disclosure of Protected Health Information and send it to your previous providers. The time you spend with your health care provider will be more productive if they are able to review your information before your appointment.

This is confidential health information that will be kept in your medical records and will not be released to anyone without your written authorization. Thank you for completing these forms and we look forward to your visit. If you have any questions about the information we are seeking, please call us at (603) 448-3122.

If known, please check the box next to the provider you would like to establish care with. For more information on each provider please visit our website at www.AlicePeckDay.org

Pediatrics

- ☐ Laura Greer, MD
- ☐ Sam Ogden, MD
- ☐ Sheilla Feyrer, MD

Please indicate your reason for transferring care to APD: _____

ALICE PECK DAY MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

10 Alice Peck Day Drive
Lebanon, NH 03766
P: (603) 448-3122
F: (603) 442-5983

AlicePeckDay.org

Revision: Feb 2021

ALICE PECK DAY MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

New Patient Intake Form
Primary Care
Multi-Specialty Clinic

Name:
MR#: place patient sticker here
DOB:

Patient Name: _____ Date of Birth:_____ Last Four SSN: _____
(last name, first name, middle initial) Birth Sex: ☐Male ☐Female
Mailing Address:_____
(Street) (City/State/Zip)
Physical Address (if different from mailing):_____
Home Phone:_____ Cell Phone:_____
Marital Status: ☐Married ☐Single ☐Divorced ☐Widow
Race: ☐White ☐African American ☐American Indian ☐Asian ☐Other
Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino
Primary Care Provider:_____
Primary Language:_____ E-Mail address:_____
Employer:_____ Occupation:_____
Work Phone:_____
Preferred Pharmacy:_____
Preferred Name (what do you prefer we call you, if different than above):_____

FIRST INSURANCE INFORMATION:

Plan Name:_____ Policy Number:_____
Address:_____ Group Number:_____
Policy Holder:_____ Policy Holder's Date of Birth:_____
Policy Holder's Relation to Patient:_____ Effective Date:_____

SECOND INSURANCE INFORMATION:

Plan Name:_____ Policy Number:_____
Address:_____ Group Number:_____
Policy Holder:_____ Policy Holder's Date of Birth:_____
Policy Holder's Relation to Patient:_____ Effective Date:_____

PARENT/GUARDIAN or PERSON RESPONSIBLE FOR BILL (Complete only if different from patient):

Name:_____ Social Security Number:_____
Address:_____
Home Phone:_____ Relation to Patient:_____

PRIOR HEALTH CARE/ADVANCE DIRECTIVES:

Last Primary Healthcare Provider – Name & Location:_____
Do you have a **Living Will**: ☐Yes ☐No
Do you have a **Durable Power of Attorney** for Health Care: ☐Yes ☐No
If yes, who:_____ Relationship:_____
Phone number:_____

ALICE PECK DAY MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

New Patient Intake Form
Primary Care
Multi-Specialty Clinic

Name:

MR#: place patient sticker here

DOB:

PAST MEDICAL HISTORY (check only if applies):

- ☐ ADD or ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Benign Breast Disease
- ☐ Bipolar
- ☐ Chlamydia (sexually transmitted infection)
- ☐ Chronic Hepatitis or Liver Disease
- ☐ Chronic Kidney Disease
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Diverticulitis
- ☐ DVT (blood clot in leg)
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ GERD or reflux disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Stones
- ☐ Migraine Headaches
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Psoriasis
- ☐ Pulmonary Embolism (blood clot in lung)
- ☐ Recurrent Urinary Tract Infections
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Street Drug Use
- ☐ Stroke
- ☐ Thyroid Disease

- ☐ Other disease not listed above: _____
- ☐ Other disease not listed above: _____
- ☐ Cancer – Type: _____
- ☐ Cancer – Type: _____
- ☐ Hospitalization – Reason/Year: _____
- ☐ Hospitalization – Reason/Year: _____
- ☐ Hospitalization – Reason/Year: _____
- ☐ Hospitalization – Reason/Year: _____
- ☐ Surgery – Type/Year: _____
- ☐ Surgery – Type/Year: _____
- ☐ Surgery – Type/Year: _____
- ☐ Surgery – Type/Year: _____

Women only: Age at first period:_____ Age at menopause:_____

# of pregnancies:_____ # of live children born:_____ # of miscarriages or abortions:_____

MEDICATIONS (Including eye drops/creams/supplements/over-the-counter medications)**:**
(list all with dose and frequency) Please attach a separate sheet if you need more room: ☐see attached

_____

_____

_____

ALLERGIES (Including medications, foods, other environmental triggers such as Latex)**:**
(give reaction details such as hives, swelling, diarrhea, etc)

_____

_____

_____

1 2 6 5 4

ALICE PECK DAY MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

New Patient Intake Form
Primary Care
Multi-Specialty Clinic

Name:

MR#: place patient sticker here

DOB:

FAMILY HISTORY (relative – for example mother, father, sibling, etc.):

☐ Heart Attack – Relative/Age:_____
☐ Heart Disease – Type/Relative:_____
☐ High Cholesterol – Relative/Age:_____
☐ Diabetes – Relative:_____
☐ Sudden Unexplained Death – Relative/Age:_____
☐ Colon Cancer – Relative/Age:_____
☐ Breast Cancer – Relative/Age:_____
☐ Cancer – Type/Relative:_____
☐ Cancer – Type/Relative:_____
☐ Other Illnesses - Relative:_____
☐ Other Illnesses - Relative:_____
☐ Other Illnesses - Relative:_____
☐ Other Illnesses - Relative:_____

SOCIAL HISTORY:

Who do you live with? _____

Do you feel safe at home? ☐ Yes ☐ No Have you ever felt threatened in your home? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes – how much per day:_____ for how long:_____

Did you smoke in the past? ☐ Yes ☐ No If yes – how much:_____ for how long:_____

Do others at home smoke? ☐ Yes ☐ No If yes – who:_____

Do you chew tobacco? ☐ Yes ☐ No If yes – how much:_____ for how long:_____

Do you drink alcohol? ☐ Yes ☐ No If yes – how many drinks per week:_____

Do you use marijuana? ☐ Yes ☐ No

Do you use other street drugs ☐ Yes ☐ No If yes – what:_____

Sexual partners (now or in past): ☐ Male ☐ Female ☐ Both ☐ None

PREVENTATIVE HEALTH CARE INFORMATION (approximately**):**

Last Physical Exam:	Date: _____		
Last blood test for Cholesterol:	☐ Normal	☐ Abnormal	Date: _____
Last blood test for Sugar/Diabetes:	☐ Normal	☐ Abnormal	Date: _____
Last Pap smear:	☐ Normal	☐ Abnormal	Date: _____
Last Mammogram:	☐ Normal	☐ Abnormal	Date: _____
Last Colon Cancer screen:	☐ Normal	☐ Abnormal	Date: _____
Have you had a Pneumonia shot?	☐ Yes	☐ No	Date: _____
Have you had a Shingles shot?	☐ Yes	☐ No	Date: _____
Do you recall last Tetanus?	☐ Yes	☐ No	Date: _____

12654

ALICE PECK DAY MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

HIPAA Compliant Authorization for Disclosure of Protected Health Information
Primary Care – Multi-Speciality Clinic

Name:_____ DOB:_____ MRN:_____

I authorize _____ to disclose my protected health information for the following purpose of **Continuity of Care**.

I understand this information may include treatment for drug/alcohol abuse, mental illness, HIV status, or genetic testing records. I specifically authorize the release of this information (if applicable):

☐Yes ☐No Initials:_____

Name of person(s) or entity to receive information:

Primary Care at Multi-Speciality Clinic
Alice Peck Day Memorial Hospital
10 Alice Peck Day Drive
Lebanon, NH 03766-2674

INFORMATION TO BE DISCLOSED:

Information Needed:

☒Problem List	☒Last year of progress notes	☒Last five years of images/labs
☒Immunization	☒Last physical	☒Last pap
☒Medication List	☒Last five years of consults	☒Last CMP and CBC

I understand that:

- I may refuse to sign this authorization and my healthcare and payment of my healthcare will not be effected based upon refusal to sign the authorization.
- I may revoke this authorization at any time by delivering to the health care provider/institution, authorized above, in a written note. I understand that the revocation will not apply to records that have been disclosed prior to receipt of the written revocation.
- If I authorize disclosure of my protected health information, and the recipient is not a covered entity, the recipient may further disclose this information and federal law will no longer protect it.
- I have the right to inspect of copy the information that I am consenting to release within the established policies of the provider or institution that I authorize to release my records.

This authorization will expire one year from the date this document is signed unless I otherwise specify an alternative date or event described here:_____

_____ _____ _____
Signature of Patient/Personal Representative Phone Number Date

_____ _____
Printed Name of Personal Representative Legal Authority of Personal Representative

We will provide you a copy of this authorization at your request.