



Welcome to APD

Dear Patient,

Thank you for selecting 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 by fax or mail in the self-addressed envelope we've provided.

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 he/she is 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 circle the provider you would like to establish care with. For more information on each provider, please visit our website at www.AlicePeckDay.org

Internal Medicine

- Sari Galanes, MD

Family Practice

- Margot Stephens, MD (0-64 years old)

Geriatrics

- Joanne Hayes, ARNP

Pediatrics

- Laura Greer, MD
- Sheila Feyrer, MD
- Sam Ogden, MD

Please indicate your reason for transferring care to APD: _____



10 Alice Peck Day Drive
Lebanon, NH 03766

P: (603) 448-3122
F: (603) 442-5131

AlicePeckDay.org   



New Patient Intake Form
Primary Care
Multi-Specialty Clinic

Name:
MR#: place patient sticker here
DOB:

Patient Name: (last name, first name, middle initial)
Date of Birth: Last Four SSN:
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:





New Patient Intake Form
Primary Care
Multi-Specialty Clinic

Name: _____

MR#: _____ place patient sticker here

DOB: _____

PAST MEDICAL HISTORY (check only if applies):

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





**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: | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Date: _____ | |
| Last blood test for Sugar/Diabetes: | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Date: _____ | |
| Last Pap smear: | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Date: _____ | |
| Last Mammogram: | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Date: _____ | |
| Last Colon Cancer screen: | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Date: _____ | |
| Have you had a Pneumonia shot? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | |
| Have you had a Shingles shot? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | |
| Do you recall last Tetanus? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | |





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:

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Problem List | <input checked="" type="checkbox"/> Last year of progress notes | <input checked="" type="checkbox"/> Last five years of images/labs |
| <input checked="" type="checkbox"/> Immunization | <input checked="" type="checkbox"/> Last physical | <input checked="" type="checkbox"/> Last pap |
| <input checked="" type="checkbox"/> Medication List | <input checked="" type="checkbox"/> Last five years of consults | <input checked="" type="checkbox"/> 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.

