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 or drop by our office on Level 2 of the Multi-Speciality Clinic.

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
- Alexa Holleran, APRN (18 years of age and older)
- Roanna Ayers, APRN

Geriatrics
- Joanne Hayes, ARNP
- Susannah Clark, MD
- Lisa Furmanski, MD

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

Please indicate your reason for transferring care to APD: ________________________________
New Patient Intake Form
Primary Care Multi-Specialty Clinic

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: __________________________
**New Patient Intake Form**  
**Primary Care**  
**Multi-Specialty Clinic**

**Name:**
**MR#:**
**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
- Diabetes 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)
New Patient Intake Form
Primary Care
Multi-Specialty Clinic

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? 

- [ ] Yes  [ ] No  Have you ever felt threatened in your home?  
- [ ] Yes  [ ] No  If yes – how much per day:     for how long:

Do you smoke?  

- [ ] Yes  [ ] No  If yes – how much:     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:     

(name)  (MR#)  (DOB)  (place patient sticker here)
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:

- [X] Problem List
- [ ] Last year of progress notes
- [X] Last five years of images/labs
- [X] Immunization
- [ ] Last physical
- [ ] Last pap
- [X] Medication List
- [ ] Last five years of consults
- [X] 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.