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: ____________________________

10 Alice Peck Day Drive
Lebanon, NH 03766
P: (603) 448-3122
F: (603) 442-5983
New Patient Intake Form
Primary Care
Multi-Specialty Clinic

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

DOB: __________

(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

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

<table>
<thead>
<tr>
<th>FAMILY HISTORY (relative – for example mother, father, sibling, etc.):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Heart Attack – Relative/Age:</td>
</tr>
<tr>
<td>☐ Heart Disease – Type/Relative:</td>
</tr>
<tr>
<td>☐ High Cholesterol – Relative/Age:</td>
</tr>
<tr>
<td>☐ Diabetes – Relative:</td>
</tr>
<tr>
<td>☐ Sudden Unexplained Death – Relative/Age:</td>
</tr>
<tr>
<td>☐ Colon Cancer – Relative/Age:</td>
</tr>
<tr>
<td>☐ Breast Cancer – Relative/Age:</td>
</tr>
<tr>
<td>☐ Cancer – Type/Relative:</td>
</tr>
<tr>
<td>☐ Cancer – Type/Relative:</td>
</tr>
<tr>
<td>☐ Other Illnesses - Relative:</td>
</tr>
<tr>
<td>☐ Other Illnesses - Relative:</td>
</tr>
<tr>
<td>☐ Other Illnesses - Relative:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL HISTORY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who do you live with?</td>
</tr>
<tr>
<td>Do you feel safe at home? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Have you ever felt threatened in your home? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Do you smoke? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes – how much per day: _______ for how long: _______</td>
</tr>
<tr>
<td>Did you smoke in the past? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes – how much: _______ for how long: _______</td>
</tr>
<tr>
<td>Do others at home smoke? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes – who: _______</td>
</tr>
<tr>
<td>Do you chew tobacco? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes – how much: _______ for how long: _______</td>
</tr>
<tr>
<td>Do you drink alcohol? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>If yes – how many drinks per week: _______</td>
</tr>
<tr>
<td>Do you use marijuana? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Do you use other street drugs ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Sexual partners (now or in past): ☐ Male ☐ Female ☐ Both ☐ None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREVENTATIVE HEALTH CARE INFORMATION (approximately):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Physical Exam: Date: ___________</td>
</tr>
<tr>
<td>Last blood test for Cholesterol: ☐ Normal ☐ Abnormal Date: ___________</td>
</tr>
<tr>
<td>Last blood test for Sugar/Diabetes: ☐ Normal ☐ Abnormal Date: ___________</td>
</tr>
<tr>
<td>Last Pap smear: ☐ Normal ☐ Abnormal Date: ___________</td>
</tr>
<tr>
<td>Last Mammogram: ☐ Normal ☐ Abnormal Date: ___________</td>
</tr>
<tr>
<td>Last Colon Cancer screen: ☐ Normal ☐ Abnormal Date: ___________</td>
</tr>
<tr>
<td>Have you had a Pneumonia shot? ☐ Yes ☐ No Date: ___________</td>
</tr>
<tr>
<td>Have you had a Shingles shot? ☐ Yes ☐ No Date: ___________</td>
</tr>
<tr>
<td>Do you recall last Tetanus? ☐ Yes ☐ No Date: ___________</td>
</tr>
</tbody>
</table>
HIPAA Compliant Authorization forDisclosure 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
- [ ] Immunization
- [ ] Medication List
- [ ] Last year of progress notes
- [ ] Last physical
- [ ] Last five years of images/labs
- [ ] Last five years of consults
- [ ] Last pap
- [ ] 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.