Welcome to APD

Dear Patient,
Thank you for selecting Alice Peck Day Memorial Hospital for your healthcare needs. Attached are forms that include a personal health history, a medication list, and a release of information. Please complete these forms and return them to us via fax (603) 442-5193 or by e-mail: patientservices@apdmh.org

Your history and your records from your previous healthcare 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 new healthcare provider will be more productive if they are able to review your information before your appointment.

This confidential health information 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 AlicePeckDay.org

Pediatrics

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

Family Medicine

☐ Anne Johnson, MD
☐ Emily Sieglinger, APRN
☐ Peter Rippberger, DO
☐ Sadie Smith, APRN

Dartmouth Health
Alice Peck Day Memorial Hospital

New Patient Intake Form
Primary Care

Name:

MR #: place patient sticker here

Patient Name:_____ Date of Birth:_____ Last Four SSN:_____
(last name, first name, middle initial)
Birth Sex: ☐Male ☐Female
Gender Identity: ☐Male ☐Female

Preferred Name (what do you prefer we call you, if different than above):_____
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:_____

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

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

PARENT/GUARDIAN or PERSON RESPONSIBLE FOR BILL (complete only if different from patient):
Name: _____ Social Security Number: _____
Address: _____
(Street) (City/State/ Zip)
Home Phone: _____ Relation to Patient: _____

PRIOR HEALTHCARE/ADVANCE DIRECTIVES
Last Primary Healthcare Provider Name: _____
Last Primary Healthcare Provider Address: _____

Do you have a Living Will: Yes ☐ No
Do you have a Durable Power of Attorney for Healthcare: ☐ Yes
If yes, who: _____ Relationship: _____
Phone number: _____

Dartmouth Health
Alice Peck Day Memorial Hospital

New Patient Intake Form
Primary Care

Name:

MR #: place patient sticker here

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
- ☐ 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
- ☐ HIV
- ☐ Kidney Stones
- ☐ Migraine Headaches
- ☐ Osteoarthritis
- ☐ Osteoporosis/Osteopenia
- ☐ Psoriasis
- ☐ Pulmonary Embolism (blood clot)
- ☐ Recurrent Urinary Tract Infections
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Street Drug Use
- ☐ Stroke
- ☐ Other disease note listed above: _____
- ☐ Other disease note 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 of 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.)

_____
_____
_____
_____
_____
_____

ALLERGIES (Including medications, foods, other environmental triggers such as Latex. Give reaction details such as hives, swelling, diarrhea, etc.)

_____
_____
_____
_____
_____
_____

Dartmouth Health
Alice Peck Day Memorial Hospital

New Patient Intake Form
Primary Care

Name:

MR #: place patient sticker here

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: _____
☐ 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? _____
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 HEALTHCARE 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 you last tetanus shot? ☐ Yes ☐ No Date: _____

Dartmouth Health
Alice Peck Day Memorial Hospital

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

Name: _____ MRN: _____ DOB _____

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-Specialty Clinic
Alice Peck Day Memorial Hospital
10 Alice Peck Day Drive
Lebanon, NH 03766
Fax: 603-442-5193

INFORMATION TO BE DISCLOSED: Information Needed:

X Problem List	X Last year of progress notes	X Last five years of images/labs
X Immunization	X Last physical	X Last pap
X Medication List	X 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 healthcare provider/institution, authorized above, in a written note. I understand that 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.

If I have the right to inspect a copy of 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 in 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.

Dartmouth Health
Alice Peck Day Memorial Hospital

Gynecology Consult (if applicable)

Patient Name: _____ Date of Birth: _____
last name, first name, middle initial)

Mailing Address: _____
(Street) (City/State/ Zip)

Physical Address (if different from mailing):)_____

Home Phone:_____ Cell Phone: _____

Pregnancy Summary (How Many?)
Please provide date of terminations, miscarriages, and ectopic pregnancies.

Total # of Pregnancies	Full Term Births (more than 37 weeks)	Premature Births (less than 37 weeks)	Terminations	Miscarriages (was surgery needed)	Ectopic Pregnancies (left or right)	Number of living children

Comments: _____

Child's Birth Date (mm/dd/yr)	# of weeks at delivery	Length of Labor	Birth Weight	Name M or F	Type of delivery (vaginal or c/s)	Anesthesia	Complications or problems	Physician	Location

Please include any D&C, D&E, Colposcopy, Cryotherapy, or Colonoscopy Surgeries

Surgery	Reason	When