

Dear Patient,

Thank you for choosing the New London Medical Group for your medical needs. Our goal is to provide you with quality care every time.

To ensure that the New London Medical Group team has all of your medical information, we ask that you complete and sign the attached Authorization for Release of Medical Records so we may request your records from your previous medical provider. Please note that if you do not fill in the entire Medical Record release form it will hold up the request of your records and delay your first appointment. Your records may take up to 30 days to receive; you will be contacted once your records have been processed.

Also, please complete the Patient Information and Patient History forms. You may return all forms by mail or drop them off at the main reception desk.

If you have a provider preference, please select: Male Female

Your provider preference will be taken into consideration by the Medical Group Leadership who reviews the new patient requests.

If you have any questions, please contact us at 603-526-5544. The New London Medical Group team looks forward to taking care of your healthcare needs.

New London Hospital
Medical Group
273 County Rd, New London, NH 03257

PATIENT INFORMATIONName: _____
Last First MIPhone: _____
Home Work Cell

Mailing Address: _____

Street Address: _____

Sex: M F DOB: ____/____/____ SSN: _____Marital Status: M S D W SepEmployed: FT PT Self Ret Military Not employedEmployer: _____ Student: FT PT

Spouse's Name: _____ Spouse's Phone: _____

Emergency Contact (other than spouse): _____

Phone: _____ Relationship: _____
_____**PEDIATRIC DEMOGRAPHICS**1st Legal Parent/Guardian: _____ Relationship: _____Physical Address: _____
(If different from above) Street, City, St, Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

2nd Legal Parent/Guardian: _____ Relationship: _____Physical Address: _____
(If different from above) Street, City, St, Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Note: (custody arrangements, adoption, language or communication barriers, etc.) _____

_____**Please bring foster/adoption documentation to your first visit if applicable.**



PERMISSION TO SEND HEALTH INFORMATION TO DARTMOUTH HEALTH

Use this form when you want your records sent to Dartmouth Health from another provider/facility.

PATIENT INFORMATION and SENDER fields with authorization statement: I authorize: Name of Provider/Facility: Address: City: State: Zip: Fax: ()

RECIPIENT: To share (disclose) my health information with Dartmouth Health, please send my records to the following Dartmouth Health member location: Alice Peck Day, Cheshire Medical Center, Dartmouth Hitchcock Medical Center, Hanover Psychiatry, Manchester, Nashua & Concord - DH, New London Hospital, Newport Health Center, Visiting Nurse and Hospice for VT/NH

If mailing my information, please return requested records to the following department/section or provider:

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: to

- Discharge Summary, Inpatient Progress Notes, Outpatient Visit (Office) Notes, Other, Emergency Department Reports, Laboratory/Pathology Reports, School Physical Forms, Records from a Specific Provider, Immunizations, Operative Reports, X-Ray Reports, X-Ray Films

For the following purpose:

SENSITIVITE HEALTH INFORMATION

If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. I understand and agree that this information will be sent to Dartmouth Health to include the location noted above UNLESS I place my initials in the applicable space below, next to the type of records:

- Mental health treatment records, Genetic testing, HIV/AIDS test results, Sexually transmitted disease (STD) treatment records, Alcohol/drug abuse treatment records

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless I specify a different date here: (date). I or my Personal Representative may revoke this authorization at any time by providing notice as specified in the sending provider's Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that: Dartmouth Health and [SENDER NAME] will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. Once this information is shared with the recipient I have specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations. My sending healthcare provider may require fees to process my request.

Signature of Patient or Personal Representative, Date, Printed Name of Patient or Personal Representative, Description of Personal Representative's Authority

INSTRUCTIONS:

How to use the “Permission to Send Health Information to Dartmouth Health” form.

This form should be used when you want your healthcare provider to send your medical records to Dartmouth Health. If you want Dartmouth Health to send your medical records to another healthcare provider or other third party, please use the “Permission to Share Patient Health Information” authorization form. You can find the form at: <https://www.dartmouth-hitchcock.org/patients-visitors/medical-records-release-forms>.

Please note that sending a healthcare provider’s office notes may have additional requirements for authorizing records to be released to Dartmouth Health.

PATIENT INFORMATION

Complete each box as indicated with the following information:

- Patient’s name (please print clearly)
- Patient’s date of birth
- Patient/Personal Representative’s phone number
- Patient’s mailing address, including City, State, and Zip Code

SENDER

Please fill in which healthcare provider/facility you are authorizing to send your medical records to Dartmouth-Hitchcock including:

- Provider/facility name
- Mailing address including Street, City, State, and Zip Code
- Fax number for the healthcare provider/facility

RECIPIENT

Check the Dartmouth Health location where you would like your information sent. You may check multiple locations. If you would like your records to be sent to a specific healthcare provider at Dartmouth Health, please fill in the appropriate provider’s name or department/section (e.g., Pediatrics, Orthopaedics, etc.).

HEALTH INFORMATION TO BE SHARED

Fill in the date range that applies to the health information you are requesting to be sent to Dartmouth Health.

Check the box(es) that describe the information you are requesting to be sent to Dartmouth Health.

- For multi-provider group practices, you can indicate you want to have records sent from only a specific provider by checking the “Records from a specific provider” box and filling in the relevant provider’s name.

Fill in a description of the purpose of the requested records. Examples: Transfer to new provider, facilitate treatment, summarize treatment, etc. **This section must be completed in order for the form to be valid.**

SENSITIVE HEALTH INFORMATION

Depending on the state where your healthcare provider practices, additional laws and/or signature requirements may apply to releases of “sensitive” categories of health information. **If you do not place your initials in the spaces provided**, the healthcare provider may release such sensitive information as necessary to fulfill your request.

DURATION & REVOCATION

Your authorization will remain valid for one year from the date of your signature, unless you specify a different date in the space provided. You have the right to revoke your permission at any time. Note that your revocation will not apply to any previously released information. Please revoke by following the directions in the healthcare provider’s Notice of Privacy Practices, or call the provider’s office where your records are located.

ADDITIONAL INFORMATION

Please read this section on the form. Please fill in the blank space with the sending healthcare provider’s name.

SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign the form in addition to their parent/legal guardian, depending on the type of care received. This will be determined by the sending healthcare provider’s protocol.

If you are not the patient, describe your relationship and legal authority to sign on behalf of the patient. In some cases, you may be required to provide legal paperwork verifying your legal authority (e.g., court-appointed guardian, power of attorney for health care). Check with the sending healthcare provider’s office regarding these requirements.

| | | | |
|---|---|--|--|
| <input type="checkbox"/> Alice Peck Day Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 308-0026 Fax: (603) 640-1970 Email: medicalrecords@apdmh.org | <input type="checkbox"/> Cheshire Medical Center HIM Department 590 Court Street Keene, NH 03431 Ph: (603) 354-547 Fax: (603) 676-4253 Email: cmcroi@cheshire-med.com | <input type="checkbox"/> Dartmouth Hitchcock Medical Center Release of Information 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869 Email: Lebanon.Release.of.Information@hitchcock.org | <input type="checkbox"/> Hanover Psychiatry 23 S. Main St., Suite 2B Hanover, NH 03755 Ph: (603) 277-9110 Fax: (603) 277-9154 |
| <input type="checkbox"/> Manchester, Nashua & Concord - DH Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 727-7828 Email: DH-ROI@hitchcock.org | <input type="checkbox"/> New London Hospital Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051 | <input type="checkbox"/> Newport Health Center Release of Information 11 John Stark Highway Newport, NH 03773 Ph: (603) 865-2855 Fax: (603) 863-3585 | <input type="checkbox"/> Visiting Nurse and Hospice for VT/NH Release of Information 1 Medical Center Drive Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869 Email: Lebanon.Release.of.Information@hitchcock.org |

HEALTH HISTORY

Name: _____ Date: _____

Age: _____ Birthdate: _____ Date of Last Physical Exam: _____

What is the Reason for Today's Visit? _____

| SYMPTOMS: CHECK (X) BOX FOR SYMPTOMS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR | | | | |
|---|--|--|--------------------------------------|---------------------------------------|
| GENERAL | | GENITAL/URINARY | | WOMEN ONLY |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Abnormal Pap Smear | | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Bleeding Between Periods | | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Breast Lump | | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Extreme Menstrual Pain | | |
| <input type="checkbox"/> Fever | EYE, EAR, NOSE & THROAT | | <input type="checkbox"/> Hot Flashes | |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Nipple Discharge | | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Painful Intercourse | | |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Vaginal Discharge | | |
| <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Difficulty Swallowing | Date of Last Period: | | |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Double Vision | Date of Last Pap Smear: | | |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Earache | Date of Last Mammogram: | | |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Ear Discharge | Number of Children: | | |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Hay Fever | Are You Pregnant? | | |
| GASTROINTESTINAL | | MEN ONLY | | |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Breast Lump | | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Erection Difficulties | | |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Lump in Testicles | | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Penis Discharge | | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sore on Penis | | |
| <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Vision - Flashes | CARDIOVASCULAR | | |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Vision - Halos | <input type="checkbox"/> Chest Pain | | |
| SKIN | | <input type="checkbox"/> High Blood Pressure | | |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Irregular Heartbeat | | |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hives | <input type="checkbox"/> Low Pressure | | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Itching | <input type="checkbox"/> Poor Circulation | | |
| <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Change in Moles | <input type="checkbox"/> Rapid Heart beat | | |
| <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Rash | <input type="checkbox"/> Swelling of Ankles | | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Scars | <input type="checkbox"/> Varicose Veins | | |
| <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Sores that Won't Heal | | | |
| MUSCLE/JOINT/BONE | | ALLERGIES: Medications/Substances | | MEDICATIONS YOU CURRENTLY TAKE |
| Pain, Weakness, Numbness in: | | | | |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Hips | | | |
| <input type="checkbox"/> Back | <input type="checkbox"/> Legs | | | |
| <input type="checkbox"/> Feet | <input type="checkbox"/> Neck | | | |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulders | | | |
| | | | | |
| <i>Pharmacy Name</i> | | | | |
| <i>Pharmacy Name #</i> | | | | |
| | | | | |
| HEALTH HABITS | | OCCUPATIONAL CONCERNS | | SERIOUS ILLNESS/INJURY |
| How often do you use these Substances: | | Check if your work exposes you to: | | DATE |
| Alcohol: | | Stress: <input type="checkbox"/> Yes <input type="checkbox"/> No | | OUTCOME |
| Tobacco: | | Hazardous Substances: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Caffeine: | | Heavy Lifting: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Drugs: | | Other: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Other: | | Your Occupation: | | |

HEALTH HISTORY (cont'd)

| | |
|--|-------------|
| Name: | DOB: |
| CONDITIONS: CHECK (X) BOX FOR CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR | |

| | | |
|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hernia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Measles | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Vaginal Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | |

| | | |
|-----------------------|--|---|
| | | Check (X) If your blood relatives had any of |
| FAMILY HISTORY | | the following: |

| Relation | Age | State of Health | Age at Death | Cause of Death | Disease | Relationship to You |
|-----------|-----|-----------------|--------------|----------------|------------------------|---------------------|
| Father | | | | | Arthritis, Gout | |
| Mother | | | | | Asthma, Hay Fever | |
| Brothers: | | | | | Cancer | |
| | | | | | Chemical Dependency | |
| | | | | | Diabetes | |
| | | | | | Heart Disease, Strokes | |
| Sisters: | | | | | High Blood Pressure | |
| | | | | | Kidney Disease | |
| | | | | | Tuberculosis | |
| | | | | | Other | |

| HOSPITALIZATIONS | | | PREGNANCY HISTORY | | |
|------------------|------------------|------------------|-------------------|--------|---------------|
| Year | Name of Hospital | Reason & Outcome | Year of Birth | Gender | Complications |
| | | | | M/F | |
| | | | | M/F | |
| | | | | M/F | |
| | | | | M/F | |
| | | | | M/F | |
| | | | | M/F | |

Have you ever had a Blood Transfusion? Yes No If Yes, Approximate Date(s) ?



Designation of Personal Representative

MRN:

NAME:

DOB:

Two identifiers needed or Patient label

I hereby designate the following Personal Representative to assist me in exercising my health information rights under the New Hampshire Patients' Bill of Rights and the federal HIPAA Privacy Rule, as indicated below:

Name _____ Relationship _____

Address _____ Phone Number _____

Verbal Conversations:

I permit the staff at Dartmouth Health comprised of: Dartmouth Hitchcock Medical Center (DHMC) and Dartmouth Hitchcock Clinics (DHC); Cheshire Medical Center; Alice Peck Day Memorial Hospital (APD); New London Hospital, including Newport Health Center (NLH); Hanover Psychiatry (HP), and Visiting Nurse and Hospice for VT and NH (VNH), to discuss my protected health information, in person or by telephone, with the person named above. This includes the ability to make, cancel, or reschedule appointments on my behalf and assist me in making payments or inquiring about my billing account.

Other:

In addition, I grant my Personal Representative the following:

- Proxy access to my "myDH" patient portal account;
- The ability to request or receive paper or electronic copies of my medical records;
- The ability to authorize the use or disclosure of my protected health information;
- If my Personal Representative is an employee of DHMC, DHC, Cheshire Medical Center or APD the ability to access my entire medical record electronically.

I understand and acknowledge that the protected health information I am authorizing Dartmouth Health: DHMC, DHC, Cheshire Medical Center, APD, NLH, HP, or VNH to share with my Personal Representative may contain drug/alcohol abuse, mental health, HIV, and/or genetic testing information.

I understand and acknowledge that this designation applies to all clinical areas of Dartmouth Health.

This authorization shall remain in effect until I send a written request to revoke to Dartmouth Health. Submitting a new form will revoke an existing form.

Patient's Printed Name Date

Signature of Patient or Legal Representative Legal Representative's Name (if applicable)

"Dartmouth Health (DH)" is the corporate parent of the covered entities listed below, each of which is an individual corporate entity legally separate and distinct from Dartmouth Health. Member organizations include: Alice Peck Day Memorial Hospital, Cheshire Medical Center, Mary Hitchcock Memorial Hospital and Dartmouth Hitchcock Clinic, operating jointly as "Dartmouth Health," Mt. Ascutney Hospital and Health Center, New London Hospital, Hanover Psychiatry and Visiting Nurses and Hospice for VT and NH. The DH ACE is comprised only of DH members who are currently using a single, integrated electronic medical record system, referred to sometimes as "eDH."

Patient, Family, and Visitor Code of Conduct

Our Code of Conduct is intended to maintain a safe and caring environment for all patients, staff, and family/visitors at New London Hospital

Promoting Safety and Security

- No weapons
- No illegal or dangerous items
- No alcohol
- No drugs
- No smoking, or vaping
- No photography
- No video/audio recording

Communicating and Acting in a Respectful Manner

The following are not acceptable behaviors: Discriminatory, disruptive, disrespectful, or harassing behaviors or language (oral or written) including, but not limited to:

- Offensive remarks, requests or demands about race, national origin, ethnicity, religion, sex, gender, gender identity or expression, sexual orientation, age, disability, military or immigration status
- Yelling or swearing
- Any physical or attempted assault
- Sexual or vulgar remarks or behaviors
- Disrupting another patient's care or experience
- Refusal to follow unit or practice specific policies or guidelines set forth for the patient's care and treatment. This includes excessive no shows and medical noncompliance
- Unwanted communication with a clinician or other staff member not related to clinical care

Code of Conduct Violations

- If you are a patient, you may be discharged and you may not be able to receive care in the future at New London Hospital
 - *Does not apply to emergency treatment under EMTALA****
- If you are a family member or visitor you will be asked to leave the premises and future visitation may be restricted.

If you are a patient or family member/visitor and are the target of any of these behaviors, please report your concerns to a staff member.