ALICE PECK DAY
MEMORIAL HOSPITAL
A Dartmouth-Hitchcock Affiliate

APD Gynecology - Women's Care Center
APD Multi-Specialty Clinic
Lebanon, NH 03766
(603) 448-3996 Fax: (603) 448-7423

Thank you for choosing Gynecology at Alice Peck Day Memorial Hospital for your gynecologic care. We are located at 9 Alice Peck Day Drive in Lebanon, NH. We have sent this paperwork to you to become a new patient with us, to re-establish your care with us, or because we have received a referral on your behalf from another provider.

In order to help us to see patients on time and in an efficient manner, please take a few moments to fill out the enclosed forms. Be as complete as possible.

Once this completed paperwork is received we will gladly schedule you with the first available appointment.

We look forward to your visit and hope to bring you the highest quality care possible. Thank you for doing your part to assist us in that endeavor.

ALICE PECK DAY MEMORIAL HOSPITAL
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New Patient Intake - Gynecology
Women's Care Center

Name:
MR#: place patient sticker here
DOB:

Patient Name:_____ Date of Birth: _____
(last name, first name, middle initial) Gender: ☐ 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
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Social Security Number: _____ 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 Gender: ☐ Male ☐ Female Policy Holder's SS #: _____
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 Gender: ☐ Male ☐ Female Policy Holder's SS #: _____
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:----------

(Please Print)

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Name:

MR#: place patient sticker here

DOB:

Your Name (Last):_____ (First):_____ (M.I.):_____

Date of Birth:_____ Referred Here by:_____

I Attest That the Information Here Is True and Correct to The Best of My Belief.

_____ _____

Patient Signature Date

Past Medical History

(If you have ever had any of these conditions – Please check all that apply)

Breast Conditions:
- ☐ Abnormal Mammogram
- ☐ Breast Cancer: ☐ Left ☐ Right
- ☐ Breast Implants
- ☐ Fibrocystic Breasts

Other:_____

Gyn Problems:
- ☐ Abnormal Pap Smear
- ☐ Cervical Cancer (Neoplasm)
- ☐ Dysmenorrhea (Painful Menses)
- ☐ Endometrial (Uterine) Cancer
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Herpes
- ☐ Human Papilloma Virus Infection (HPV)
- ☐ Ovarian Cancer
- ☐ Ovarian Cysts
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Sexually Transmitted Disease (STD)
- ☐ Vaginal Cancer (Neoplasm)
- ☐ Vulvar Cancer (Neoplasm)

Other:_____

Blood (Hematologic) Disorders:
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Clotting Disorder
- ☐ Sickle Cell Trait or Disease
- ☐ Thalassemia

Other:_____

Endocrine (Glandular) Disorders:
- ☐ Diabetes – Type I (Insulin-Dependent)
- ☐ Diabetes – Type II
- ☐ Pituitary Gland Disorder
- ☐ Thyroid Disease (Hypo) or (Hyper)
- ☐ High Cholesterol

Other:_____

Immune System Diseases:
- ☐ Chronic Fatigue Syndrome
- ☐ Sinus Allergies
- ☐ Systemic Lupus
- ☐ Rheumatoid Arthritis

Other:_____

Gastrointestinal (GI) Problems:
- ☐ Colitis, Ulcerative
- ☐ Crohn's Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Irritable Bowel Syndrome

Other:_____

Neurologic Disorders:
- ☐ Common Migraines
- ☐ Headaches (Other)
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder (Epilepsy)
- ☐ TIA or Stroke

Other:_____

(If you have ever had any of these conditions – Please check all that apply - continued)

Heart or Circulation Conditions (Cardiovascular):
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ CVA (Stroke)
- ☐ Hypertension (High Blood Pressure)
- ☐ Irregular Heart Beat
- ☐ Mitral Valve Disorders (MVP)
- ☐ Pulmonary Embolism (Blood Clot in Lung)
- ☐ Thrombophlebitis (Blood Clot in Extremity)

Other:_____

Psychiatric or Emotional Conditions:
- ☐ ADHD/ADD
- ☐ Bipolar (Manic-Depressive)
- ☐ Major Depression
- ☐ OCD (Obsessive-Compulsive)
- ☐ Postpartum Depression
- ☐ Severe Anxiety or Panic Attacks

Other:_____

Urinary (Urological) Disorders:
- ☐ Calculus (Kidney Stones)
- ☐ Pyelonephritis
- ☐ Stress Incontinence
- ☐ Urge Incontinence/Overactive Bladder
- ☐ Urinary Tract Infections (UTI)

Other:_____

Musculoskeletal Disorders:
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Systemic Lupus Erythematosus

Other:_____

Respiratory (Lung) or ENT Disorders:
- ☐ Asthma
- ☐ COPD
- ☐ Lung Cancer
- ☐ Pneumonia - Recurrent
- ☐ Sleep Apnea
- ☐ Tuberculosis

Other:_____

Skin Conditions:
- ☐ Acne (Severe)
- ☐ Eczema
- ☐ Hirsutism (Excess Hair Growth)
- ☐ MRSA
- ☐ Psoriasis

Other:_____

Genetic Disorders:
- ☐ Cystic Fibrosis
- ☐ Muscular Dystrophy

Other:_____

Past Surgical History
(Please include any D&C, D&E, Colposcopy, Cryotherapy or Colonoscopy Surgeries)

Surgery	Reason	When

Herbs, Vitamins and Supplements You Are Taking

Product Name	Dose (if known)	How Often	Start Date	Reason

Medications You Are Taking

Drug Name	Dose (if known)	How Often	Start Date	Prescribed By

Primary Pharmacy Name:_____ Phone:_____
Pharmacy Address:_____

Allergies

Do You Have Any Known Medication Allergies? ☐Yes ☐No
Are you allergic to any of the following (check all that apply): ☐Contrast Dye ☐Nickel
☐Peanuts ☐Latex ☐Iodine ☐Shellfish ☐Adhesive Tape ☐Band Aids
Other:_____

Please list all allergies and the allergic reaction:

Allergic To (medications, foods, environmental)	Reaction

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Family Medical History

If **Any** close relative (Brothers, Sisters, Parents, Children, Grandparent [Maternal or Paternal], Aunt/Uncle) Has Ever Had or Currently Has any of the problems listed below, place a check and enter the relationship to you

Endometriosis	☐Yes	☐No	Who (be specific):_____
Uterine Fibroids	☐Yes	☐No	Who (be specific):_____
Breast Cancer	☐Yes	☐No	Who (be specific):_____
Colon Cancer	☐Yes	☐No	Who (be specific):_____
Heart Disease	☐Yes	☐No	Who (be specific):_____
High Blood Pressure	☐Yes	☐No	Who (be specific):_____
High Cholesterol	☐Yes	☐No	Who (be specific):_____
Blood Clots	☐Yes	☐No	Who (be specific):_____
Diabetes – Type I	☐Yes	☐No	Who (be specific):_____
Diabetes – Type II	☐Yes	☐No	Who (be specific):_____
Hyperthyroidism	☐Yes	☐No	Who (be specific):_____
Hypothyroidism	☐Yes	☐No	Who (be specific):_____
Lung Cancer	☐Yes	☐No	Who (be specific):_____
Depression	☐Yes	☐No	Who (be specific):_____
Bipolar Disorder	☐Yes	☐No	Who (be specific):_____
Other Malignancies (Site):_____			
	☐Yes	☐No	Who (be specific):_____
Ovarian Cancer	☐Yes	☐No	Who (be specific):_____
Uterine Cancer	☐Yes	☐No	Who (be specific):_____
Endometrial Cancer	☐Yes	☐No	Who (be specific):_____
Osteoporosis	☐Yes	☐No	Who (be specific):_____

Menstrual History

Menopause Status: ☐Premenopausal ☐Postmenopausal ☐Perimenopausal

Age Menopause:_____

Are You Sexually Active? ☐Yes ☐No With: ☐Men ☐Women ☐Both

Age of First Menstrual Period:_____ Cycle Length (28 days or?):_____

Number days of bleeding with a period_____ Period Flow: ☐Light ☐Medium ☐Heavy

Date of Last Normal Menstrual Period (if abnormal describe):_____

_____

Birth Control Method Using Now:_____

(*Period Means # Days of Bleeding; Cycle Length Means Total # of Bleeding and Non-Bleeding Days Until the Next Period Begins)

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DOB:

Pregnancy Summary (How Many…?)

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

(please provide date of terminations, miscarriages and ectopic pregnancies)

Comments:_____

_____

Pregnancy Details

Child's Birthdate (mm/dd/yr)	Child's Name	# Weeks At Delivery	Length of Labor	Birth Weight	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications or Problems	Physician	Location

Social History

Marital Status: ☐Dating ☐Divorced ☐Engaged ☐Married ☐Not Dating
☐Separated ☐Single ☐Widowed ☐Living with Significant Other

Alcohol Use: ☐Never ☐Current ☐Former
How Much:_____ Age Started:_____ Age Stopped:_____

Illegal Drug Use: ☐Never ☐Current ☐Former
Which Drug(s):_____
How Often:_____ Age Started:_____ Age Stopped:_____
When Last Used:_____

Tobacco Use: ☐Never ☐Current ☐Former
How Much:_____ Age Started:_____ Age Stopped:_____

Caffeine Use: ☐Yes ☐No How Much:_____

Exercise Habits: ☐Sedentary ☐Active but no formal exercise
☐Minimal Amount of Exercise (once weekly or less)
☐Moderate Amount of Exercise (1-3 times weekly)
☐Heavy Amount of Exercise (4 or more times weekly)
Type of Exercise:_____

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DOB:

Occupation:_____

Hobbies:_____

Check If You Currently Have Any of the Following Symptoms

CONSTITUTIONAL:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue/Weakness
- ☐ Fever

EYES:
- ☐ Vision problem

HENT:
- ☐ Headaches

BREAST:
- ☐ Breast Lumps
- ☐ Breast Pain
- ☐ Breast Discharge
- ☐ Leaking Milk

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Short of breath on exertion
- ☐ Heart murmur
- ☐ Swelling in legs

RESPIRATORY:
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Spitting up blood
- ☐ Cough

ALLERGIC-IMMUNOLOGIC:
- ☐ Sinus allergy symptoms

GENITOURINARY:
- ☐ Not having periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Bleeding between periods
- ☐ Painful periods
- ☐ Pelvic pain
- ☐ Pain with intercourse
- ☐ Spotting with or after intercourse
- ☐ Decreased sex drive
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Difficulty starting to urinate
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Leaking urine with cough
- ☐ Leaking urine with urge

INTEGUMENTARY:
- ☐ Rash
- ☐ Itching
- ☐ New skin lesions
- ☐ Changes in existing moles

NEUROLOGIC:
- ☐ Seizures
- ☐ Dizziness
- ☐ Syncope (Fainting/Passing out)

Check If You Currently Have Any of the Following Symptoms (continued)

GASTROINTESTINAL:
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody stool

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Muscular weakness

HEMATOLOGIC
- ☐ Anemia
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph nodes

ENDOCRINE:
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Loss of hair
- ☐ Changes in hair texture
- ☐ Changes in skin texture
- ☐ Excessive hair growth

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

Well Woman Screening History

Please Indicate the Date of Your Last:

Pap:_____

Mammogram:_____

Colonoscopy:_____

Lipid Screening:_____

Glucose Test:_____

Dexa (Bone) Scan:_____

Dartmouth-Hitchcock Health

Dartmouth-Hitchcock Affiliated Covered Entity

Permission to Share Protected Health Information

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ Phone: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

FACILITY:

Please check the current location of the records you want shared:

☐ Alice Peck Day ☐ Cheshire Medical Center ☐ DH-Concord ☐ DHMC-Lebanon ☐ DH-Manchester ☐ DH-Nashua

☐ New London Hospital ☐ Other: _____

RECIPIENT: I authorize the entities listed above to release my information to:

Name of Person or Entity: _____ Phone Number: ( ) _____

Street Address: _____

City: _____ State: _____ Zip: _____

PURPOSE:

☐ Medical care ☐ Payment of health insurance claim ☐ Workers' Comp ☐ Legal ☐ Personal ☐ Disability determination

☐ Life insurance application ☐ Transfer of Care ☐ Other (please specify):_____

INFORMATION TO BE SHARED:

☐ VERBAL COMMUNICATION

☐ MEDICAL RECORDS

The records to be released will cover the time period from _____to_____

☐ Records from a specific provider: _____

☐ Discharge Summary	☐ Emergency Dept. Notes	☐ School/Camp Form	☐ Other: _____
☐ Inpatient Notes	☐ Lab/Path Reports	☐ Radiology Reports	_____
☐ Office or Clinic Notes	☐ Operative Reports	☐ Radiology Images	_____
☐ Billing	☐ Immunizations	☐ Photos	

Delivery: ☐ Patient Portal (myD-H) (*FREE!*) ☐ Pickup ☐ Mail to Recipient ☐ Fax Number: (_____)_____

Format: ☐ Paper ☐ CD

DURATION & REVOCATION:

My authorization is valid for one year from the date of my signature below, unless I specify a different date here: _____.
My Personal Representative or I may revoke this authorization at any time by providing written notice as specified in the D-H ACE Notice of Privacy Practices; however, my revocation will not apply to any previously released information.

I understand that:

- A fee for the cost of processing this request may be charged.
- D-H ACE members will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- Once this information is shared with the recipient I specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- D-H ACE members may utilize a business associate/authorized agent to assist in fulfilling this request.

SENSITIVE HEALTH INFORMATION This form authorizes D-H ACE members to release the following types of information, **UNLESS** you place your initials in the space provided:

_____ psychiatric treatment records	_____ sexually transmitted disease (STD) treatment records
_____ genetic testing	_____ substance use disorder treatment records from a 42 CFR Part 2
_____ HIV/AIDS test results	program

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**

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

INSTRUCTIONS:
How to fill out "Permission to Share Protected Health Information" authorization form

This form should be used when you want your medical records held by us to be sent to a third party.

Please complete all sections. An incomplete authorization may result in a delay in processing your request.

PATIENT INFORMATION

Complete each section as indicated with the following information:

- Patient's name (please print clearly)
- Patient's Date of Birth
- Telephone number where requester can be reached during the day
- Patient's Mailing Address, including City, State, and Zip Code

DARTMOUTH-HITCHCOCK AFFILIATED COVERED ENTITY (D-H ACE) FACILITY

Please tell us the current location of the records that you want shared.

Alice Peck Day Health Information Services 10 Alice Peck Day Drive Lebanon NH 03766 Ph: (603) 448-7433 Fax: (603) 640-1984	**Cheshire Medical Center** HIM Dept. 590 Court St. Keene, NH 03431 Ph: (603) 354-5477 Fax: (603) 354-5478	**Concord** Medical Release Dept. 253 Pleasant St. Concord, NH 03301 Ph: (603) 229-5145 Fax: (603) 229-5146	**Dartmouth-Hitchcock Medical Center** Release of Information 1 Medical Center Dr. Lebanon, NH 03756 Ph: (603) 650-7110 Fax: (603) 727-7869	**Manchester** Health Information Services 100 Hitchcock Way Manchester, NH 03104 Ph: (603) 695-2820 Fax: (603) 676-4290	**Nashua** Health Information Services 2300 Southwood Dr. Nashua, NH 03063 Ph: (603) 577-4037 Fax: (603) 577-4039	**New London Hospital** Release of Information 273 County Road New London, NH 03257 Ph: (603) 526-5247 Fax: (603) 526-5051

RECIPIENT

Tell us the individual or business entity that is to receive the information. Include:

- Recipient's or Business Entity's (Company's) Name. If the information is for your own personal use, write "Self."
- Telephone number of the person or entity who will receive the information
- Mailing address of who will receive the information, including City, State, and Zip Code

PURPOSE

Check the box that best describes the purpose for sharing your health information. If no box relates to your purpose, check "Other" and state the purpose for the release on the line provided. **This section must be filled out in order for the form to be valid.**

INFORMATION TO BE SHARED

- Indicate whether you are authorizing verbal communications or medical records release, or both.
- Fill in the date range that applies to the health information you are requesting we share.
- Check the box(es) that apply to your request.
- You can tell us you want your records from only a specific provider by checking the "Records from a specific provider" box and filling in the relevant provider's name.

DELIVERY: Please indicate delivery preference. If no options are checked, typically the records will be sent via USPS.

FORMAT: Please indicate whether you want the records in paper format or in electronic format (PDF) on an encrypted CD.

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. Please revoke by following the directions in our Notice of Privacy Practices, available on our website, or contact the Privacy Office at PrivacyOffice@hitchcock.org or 1-844-754-8250.

ADDITIONAL INFORMATION

Please read. Sometimes there is a fee for sending your records. Please call for any questions around fees.

SENSITIVE HEALTH INFORMATION

If you do not place your initials in the space provided, we **WILL** release sensitive information contained in your medical record as necessary to fulfill your request. For more information on how we share your sensitive information, please refer to our Notice of Privacy Practices, available on our website, or contact the Privacy Office at PrivacyOffice@hitchcock.org or 1-844-754-8250.

SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign this form, depending on the type of care received.

If you are not the patient, describe your relationship to the patient and legal authority to sign. In some cases, you will be required to provide legal paperwork verifying your authority (e.g., court-appointed guardian, power of attorney for health care, appointment from court of executorship/administrator of decedent's estate).