



Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Primary Language \_\_\_\_\_ Secondary Language \_\_\_\_\_

☐ Deaf ☐ ASL

Would you like help completing this form? ☐ Yes ☐ No

**If yes**, please bring this form back to the front desk as soon as possible.

1. Are you a U.S. Veteran: ☐ Yes ☐ No

2. Sex Assigned at Birth: ☐ Male ☐ Female

3. Current Gender Identity:

☐ Male

☐ Female

☐ Decline

☐ Other \_\_\_\_\_

☐ Transgender  
Female (MTF)

☐ Transgender  
Male (FTM)

☐ Gender  
Non-  
Conforming

(Optional): Pronouns, please list them here: \_\_\_\_\_

4. Sexual Orientation:

☐ Heterosexual  
(Straight)

☐ Homosexual  
(Gay/Lesbian)

☐ Bisexual

☐ Non-  
binary

☐ Decline/Other: \_\_\_\_\_

5. Marital  
status:

☐ Single

☐ Married

☐ Divorced

☐ Domestic  
Partnership

☐ Widowed

☐ Separated

☐ Cohabitation

### Race / Ethnicity

Check all that apply to you:

\_\_\_\_ White

\_\_\_\_ Black

\_\_\_\_ Asian

\_\_\_\_ Pacific Islander (Fijian, Samoan,  
etc)

\_\_\_\_ American  
Indian/Native  
American

\_\_\_\_ Latinx

\_\_\_\_ Other

☐ Hispanic

☐ Non Hispanic or Latino

Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Case Management

Are you currently receiving case management services? ☐Yes ☐No ☐N/A

If yes, please provide the below information

_____ Name	_____ Agency	_____ Phone Number
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### Guardian information

If you have an *activated* Medical Durable Power of Attorney (DPOA/Agent) or Guardian, please provide the information below.

_____ Print Name	_____ Phone Number
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☐Guardian

☐DPOA

Have you provided us with your legal documents? ☐Yes ☐No

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**Please carefully read the policies below and initial next to each to show understanding:**

#### No Show Policy

\_\_\_\_\_ A “No Show” is the term we use when a patient misses an appointment without cancelling it prior to the appointment. A failure to attend a scheduled appointment will be recorded in your medical chart as a “No Show”. Three (3) “No Show” appointments in a rolling 12 months will result in a dismissal from all Valley Regional Primary Care Practices. If you will be more than 10 minutes late for your appointment, please call the office to reschedule your appointment.

#### Prescription Refill Policy

\_\_\_\_\_ Please allow up to 3 business days (72 hours) for refill requests. Please note that we do not typically order antibiotics over the phone. Our practice does not routinely order Narcotic Pain Medicine; therefore, you may be required to obtain these medications through a Pain Management Specialist.

**Please sign below once this form is completed:**

\_\_\_\_\_  
**Print Patient's Name**

\_\_\_\_\_  
**Patient's Date of Birth**

\_\_\_\_\_  
**Patient/Guardian's Signature**

\_\_\_\_\_  
**Today's Date**

**\*Please return this form to the front desk once completed.  
Thank you!**

**Patient Information**

Last Name:

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First Name:

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Middle Initial

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Previous Last Name:

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Marital Status:

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Date of Birth (*DOB*):

---

Full Address:

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Cell Number:

---

Phone Number:

---

Social Security Number:

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Do you consent to call  
and/or text? ☐ YES ☐ NO

Email Address:

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Do you consent to the patient portal?

☐ Yes ☐ NoDo you consent to Record Sharing, so other healthcare facilities can  
view your records if needed?☐ Yes ☐ No

Do you consent to sharing Medication History with your provider?

☐ Yes ☐ NoDo you consent to sharing Immunizations records with NH Immunization  
Information System (*NHIIS*)?☐ Yes ☐ No**Emergency Contact Information**

Last Name:

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First Name:

---

Middle Initial:

---

Phone Number:

---

Relationship:

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**Insurance Information***Insurance information can be found on your insurance card, or by calling your insurance company directly.*

Policy Holder Name:

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DOB of Policy Holder:

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Insurance Company:

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ID/Policy Number:

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Group Number:

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Insurance Company Address:

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Employer:

---

Employer Phone:

---

Full Employer Address:

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Effective Date: 

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*\* Please call your insurance company to update your primary care provider information. \**

**REQUEST FOR USE AND/OR DISCLOSURE OF Protected Health Information Authorization Form**

**Authorization is also valid for the following Valley Regional Hospital departments:**

Associates In Medicine	Valley Primary Care	Valley Regional Urology
Valley Regional Surgical Associates	Valley Regional Orthopedics	Women's Health
Valley Regional Urgent Care	Valley Regional Emergency Room	

**Patient Information:**

Full legal name:	DOB:
Phone number:	Email:

I authorize the use and disclosure of my protected health information as indicated below. The purposed of this disclosure is for the following reason(s) **(please initial)**: ☐ Further Medical Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ School ☐ Transfer of Care ☐ Other: \_\_\_\_\_

**The Information is to be disclosed/released by:**

**The Information is to be released/sent to:**

Name:	Name:
Address:	Address:
City & State:	City & State:
Zip:	Zip:
Phone: <b>Fax:</b>	Phone: <b>Fax:</b>
Email:	Email:

By **initialing** the spaces below, I authorize the release of the following records, if such records exist:

<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	History and Physical	<input type="checkbox"/>	Operative/procedure note
<input type="checkbox"/>	Consultations	<input type="checkbox"/>	Progress notes	<input type="checkbox"/>	Emergency Dept Records
<input type="checkbox"/>	Labs, Xrays, EKGs, etc.	<input type="checkbox"/>	Outpatient Clinic Notes	<input type="checkbox"/>	
<input type="checkbox"/>	Other:				

Dates of treatment: \_\_\_\_\_ Last 3 years (please initial) Specific Dates: From: \_\_\_\_\_ To: \_\_\_\_\_

**Additionally, the information disclosed may include the following and I authorize such disclosure (Please initial):**

<input type="checkbox"/>	Mental Health Treatment	<input type="checkbox"/>	HIV/AIDS related illness	<input type="checkbox"/>	Drug/Alcohol Treatment***
<input type="checkbox"/>	Sexually Transmitted disease	<input type="checkbox"/>	Hepatitis Status	<input type="checkbox"/>	Genetic Testing
<input type="checkbox"/>	Psychotherapy Notes	***Further disclosure prohibited or governed by 42 CFR Part 2			

**Route of delivery (please circle):**

Paper copies Fax (provider/hospitals only) CD Secure Email

- I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
- I understand that the Valley Regional Hospital shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- I understand that this authorization may be revoked in writing and delivered to the \_\_\_\_\_ Department of Valley Regional Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed as a result of this authorization could be re-disclosed by the receiver and, if so, may not be subject to federal or state law protecting its confidentiality.

Date

Signature of individual or representative/ **Print name signed**

Witness

Print Name Signed

(Authority of relationship of representative)

EXPIRATION DATE: This authorization will expire on (date no later than one year from now) \_\_\_\_\_.

(If no date is stated, this authorization expires six months from the date it was signed.)