Dartmouth Health

Valley Regional Hospital

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

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

☐Guardian

☐DPOA

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

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 that 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!

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Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Previous Last Name: _____ Marital Status: _____ Date of Birth: _____

Full Address: _____

Cell Number: _____ Phone Number: _____ SSN: _____

Do you consent to call and text? ☐ **Yes** ☐ **No**

Email address: _____

If Child, name of Mother _____ DOB _____

If Child, name of Father _____ DOB _____

Do you consent to the patient portal? ☐ Yes ☐ No

Emergency Contact Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

Phone Number: _____ Relationship: _____

Insurance Information

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

Sub Name: _____ DOB _____ Insurance Company: _____

Company Address: _____

ID/Policy Number: _____ Group Number: _____

Employer: _____ Employer Phone: _____

Employer address: _____ City/State: _____

Effective Date: _____ Phone: _____

Dartmouth Health

Valley Regional Hospital
243 Elm Street, Claremont, NH 03743

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**:** **Fax:**	Phone**:** **Fax:**
Email:	Email:

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

	Discharge Summary		History and Physical		Operative/procedure note
	Consultations		Progress notes		Emergency Dept Records
	Labs, Xrays, EKGs, etc.		Outpatient Clinic Notes		
	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):

	Mental Health Treatment		HIV/AIDS related illness		Drug/Alcohol Treatment***
	Sexually Transmitted disease		Hepatitis Status		Genetic Testing
	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.)