Dartmouth Health

Valley Regional Hospital

Patient Information

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

Previous Last Name: _____ Marital Status: _____ Date of Birth (DOB): _____

Full Address: _____

Cell Number: _____ Phone Number: _____ SSN: _____

Email address: _____

If Child, name of Mother _____ DOB_____

If Child, name of Father _____ DOB_____

Do you consent to call and text?	☐ Yes ☐ No
Do you consent to the patient portal?	☐ Yes ☐ No
Do 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 ☐ No
Do you consent to sharing Immunizations records with NH Immunization Information System (NHIIS)?	☐ Yes ☐ No

Emergency Contact Information

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

Address

_____

Phone Number: _____ Relationship: _____

Second Emergency Contact

Last Name: _____

First Name: _____

Middle Initial: _____

Address

_____

Phone Number: _____

Relationship: _____

Insurance Information

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

Policy Holder Name: _____

Policy holder's DOB: _____

Insurance Company: _____

ID/Policy Number: _____

Group Number: _____

Insurance Company Address: _____

Employer Name: _____

Employer Phone: _____

Full Employer Address: _____

City/State: _____

Effective Date: _____

Medicare patients Only:
Medicare Id#: _____

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

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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!

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.)

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Permission to Verbally Discuss Protected Health Information with Family and Friends

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for appropriate Valley Regional Hospital staff to VERBALLY share the information I have checked with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. *(check all boxes that apply)* This form does not authorize releasing copies of my records.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/test results (☐ Check here to include HIV results)
- ☐ Billing and payment information
- ☐ Other (describe): _____

Valley Regional Hospital has my permission to discuss the above information with the following family, friends and other people. This information is directly relevant to their involvement in my health care (or payment for that care).

1 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

2 Name _____

Street address _____

City, State, Zip _____

Home phone _____ Work phone _____

I understand that in certain situations Valley Regional Hospital may speak to other individuals who are involved in my care or payment of that care, if permitted by law, which may not be identified on this form.

I understand that I have the right to revoke my permission at any time, except where Valley Regional Hospital has already made disclosures in reliance upon this request. **I understand this permission remains in effect until the time I revoke it in writing.**

Signature of Patient/Authorized Representative **X** _____ Date _____

If other than patient, state relationship and authority to sign _____