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 your New London Medical Group team has all of your medical information, we ask that you complete the highlighted areas 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 New London Hospital Medical Records Department.

The following providers are available to see new patients in the areas of infancy to elderly care:

- Elaine Silverman MD (Adult Only)
- Christine Dube APRN
- Brian Frenkiewich DO
- John Malcolm MD
- Rebecca Wood MD (Adult only)
- Amy Schneider MD
- Denise Weber MD (Adult Only)
- Griffin Manning APRN

**If you do not have a provider preference please select:** Male / Female

**Your provider preference will be taken into consideration by the Medical Director who reviews all 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.

PLEASE RETURN THIS FORM WITH YOUR PACKET
PATIENT INFORMATION

Name: _____________________  _____________________  _____  
Last      First      MI

Phone: _____________________ _____________________  __________________  
Home      Work      Cell

Mailing address: __________________________    Street Address ________________________  
________________________  ________________________

Sex: □ M  □ F  DOB: ____/____/____  SSN: ______-______-________

Marital Status: □ M  □ S  □ D  □ W  □ Sep

Employed: □ FT  □ PT  □ Self  □ Ret  □ Military  □ Not employed

Spouse’s Name: _____________________  Spouse’s Phone: __________________

Emergency Contact (other than spouse): ________________________________  
Phone: ___________________  Relationship: ___________________

Employer: ______________________________________  Student: □ FT  □ PT

GUARANTOR INFORMATION

□ Same as above: if patient is over 18 years of age

Name: _____________________  _____________________  _____  
Last      First      MI

Phone: _____________________ _____________________  __________________  
Home      Work      Cell

Mailing address: __________________________    Street Address ________________________  
________________________  ________________________

Sex: □ M  □ F  DOB: ____/____/____  SSN: ______-______-________

Employer: ______________________________________

INSURANCE INFORMATION

Insurance Company: _____________________________________________________________

Subscriber Name:  _______________________________________

Certificate #: _____________________  Group Name / Number: _____________________

Please present insurance card(s) to the front desk. Any co-payment is due at time of service.
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                      |
| Chills                          | Blood in Urine                  | Abnormal Pap Smear               |
| Depression                      | Frequent Urination              | Bleeding Between Periods         |
| Dizziness                       | Lack of Bladder Control         | Breast lump                      |
| Fainting                        | Painful Urination               | Extreme Menstrual Pain           |
| Fever                           |                                 | Hot Flashes                      |
| Forgetfulness                   |                                 |                                 |
| Headache                        |                                 |                                 |
| Loss of Sleep                   |                                 |                                 |
| Loss of Weight                  |                                 |                                 |
| Weight Gain                     |                                 |                                 |
| Nervousness                     |                                 |                                 |
| Numbness                        |                                 |                                 |
| Sweats                          |                                 |                                 |
| GASTROINTESTINAL                |                                 |                                 |
| Poor Appetite                   |                                 |                                 |
| Bloating                        |                                 |                                 |
| Bowel Changes                   |                                 |                                 |
| Constipation                    |                                 |                                 |
| Diarrhea                        |                                 |                                 |
| Excessive Hunger                |                                 |                                 |
| Excessive Thirst                |                                 |                                 |
| Gas                             |                                 |                                 |
| Hemorrhoids                     |                                 |                                 |
| Indigestion                     |                                 |                                 |
| Nausea                          |                                 |                                 |
| Rectal Bleeding                 |                                 |                                 |
| Stomach Pain                    |                                 |                                 |
| Vomiting                        |                                 |                                 |
| Vomiting Blood                  |                                 |                                 |
| GASTROINTESTINAL                |                                 |                                 |
| Poor Appetite                   |                                 |                                 |
| Bloating                        |                                 |                                 |
| Bowel Changes                   |                                 |                                 |
| Constipation                    |                                 |                                 |
| Diarrhea                        |                                 |                                 |
| Excessive Hunger                |                                 |                                 |
| Excessive Thirst                |                                 |                                 |
| Gas                             |                                 |                                 |
| Hemorrhoids                     |                                 |                                 |
| Indigestion                     |                                 |                                 |
| Nausea                          |                                 |                                 |
| Rectal Bleeding                 |                                 |                                 |
| Stomach Pain                    |                                 |                                 |
| Vomiting                        |                                 |                                 |
| Vomiting Blood                  |                                 |                                 |
| SKIN                            |                                 |                                 |
| Pain, Weakness, Numbness in:    |                                 |                                 |
| Arms                            |                                 |                                 |
| Back                            |                                 |                                 |
| Feet                            |                                 |                                 |
| Hands                           |                                 |                                 |
| MUSCLE/JOINT/BONE               | ALLERGIES: Medications/Substances | MEDICATIONS YOU CURRENTLY TAKE |
| ALLERGIES: Medications/Substances | MEDICATIONS YOU CURRENTLY TAKE |

Pharmacy Name
Pharmacy Name #

HEALTH HABITS

How often do you use these Substances:

- Alcohol: Stress: □ Yes □ No
- Tobacco: Hazardous Substances: □ Yes □ No
- Caffeine: Heavy Lifting: □ Yes □ No
- Drugs: Other: □ Yes □ No
- Other: Your Occupation:

OCCUPATIONAL CONCERNS

Check if your work exposes you to:

DATE OUTCOME

SERIOUS ILLNESS/INJURY

- Date: ____________________________
- Outcome: ____________________________

Form #: PP11
Rev Date: 8/28/2018
Page 1 of 2
**HEALTH HISTORY**

Name:  
DOB:  

**CONDTIONS: CHECK (X) BOX FOR CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST YEAR**

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

Check (X) If your blood relatives had any of the following:

<table>
<thead>
<tr>
<th>Relation</th>
<th>Age</th>
<th>State of Health</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Disease</th>
<th>Relationship to You</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td>Arthritis, Gout</td>
<td></td>
<td></td>
<td></td>
<td>Cancer</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>Asthma, Hay Fever</td>
<td></td>
<td></td>
<td></td>
<td>Chemical Dependency</td>
</tr>
<tr>
<td>Brothers:</td>
<td></td>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
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<td></td>
<td></td>
<td>Chemical</td>
<td></td>
<td></td>
<td></td>
<td>Heart Disease, Strokes</td>
</tr>
<tr>
<td>Sisters:</td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td>Kidney Disease</td>
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<td>Kidney Disease</td>
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<td>Tuberculosis</td>
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<td>Other</td>
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</tbody>
</table>

**HOSPITALIZATIONS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Name of Hospital</th>
<th>Reason &amp; Outcome</th>
<th>Year of Birth</th>
<th>Gender</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
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<td>M/F</td>
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<td>M/F</td>
<td></td>
</tr>
</tbody>
</table>

**PREGNANCY HISTORY**

<table>
<thead>
<tr>
<th>Year</th>
<th>Name of Hospital</th>
<th>Reason &amp; Outcome</th>
<th>Year of Birth</th>
<th>Gender</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
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<td>M/F</td>
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<td></td>
<td></td>
<td>M/F</td>
<td></td>
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</tbody>
</table>

Have you ever had a Blood Transfusion?  
☐ Yes  ☐ No  
If Yes, Approximate Date(s) ?
### Section A: This section must be completed for all Authorizations

<table>
<thead>
<tr>
<th>Patient Name (please include Maiden Name and/or Aliases):</th>
<th>Birth Date:</th>
</tr>
</thead>
</table>

- [ ] Obtain information from:  
- [ ] Release information to:

<table>
<thead>
<tr>
<th>Provider’s Name:</th>
<th>Recipient’s Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New London Hospital Medical Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address 1:</th>
<th>Address 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td>273 County Rd</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address 2:</th>
<th>Address 2:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New London</td>
<td>NH</td>
<td>03257</td>
</tr>
</tbody>
</table>

**Phone:** 603-526-5191  
**Fax:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

- [ ] Date:  
- [ ] Event:

**Purpose of disclosure:**

**Preferred Provider:**

**Format of Record:**  
- [ ] Paper  
- [ ] CD

**Description of information to be used or disclosed**

<table>
<thead>
<tr>
<th>Is this request for psychotherapy notes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.</td>
</tr>
<tr>
<td>[ ] No, then you may check as many items below as you need.</td>
</tr>
</tbody>
</table>

**Description:**  

<table>
<thead>
<tr>
<th>Date(s):</th>
<th>Description:</th>
<th>Date(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete Medical Record</td>
<td></td>
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<td></td>
<td>Admission forms</td>
<td></td>
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<tr>
<td></td>
<td>H&amp;P/Discharge Summary</td>
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<td></td>
<td>Physician orders</td>
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<td></td>
<td>Physician Progress Notes</td>
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<td></td>
<td>Medication Records</td>
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<td></td>
<td>Laboratory Reports</td>
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<td></td>
<td>Radiology Reports</td>
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<td></td>
<td>Radiology Images (on CD)</td>
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<td></td>
<td>Special tests</td>
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<td></td>
<td>Rehab Notes</td>
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<td></td>
<td>Nursing Notes</td>
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<td></td>
<td>Transfer forms</td>
<td></td>
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<td></td>
<td>Emergency Room Records</td>
<td></td>
</tr>
</tbody>
</table>

### Section B: Is the request of PHI for the purpose of marketing?

If yes, the health care provider must complete Section B, otherwise skip to Section C.

**Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?**  
- [ ] Yes  
- [ ] No

**If yes, describe:**

### Section C: Signatures

**I have read the above and authorize the disclosure of the protected health information as stated.**

<table>
<thead>
<tr>
<th>Signature of Patient/Guardian/Patient Representative:</th>
<th>Date:</th>
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<table>
<thead>
<tr>
<th>Print Name of Patient/Patient Representative:</th>
<th>Relationship to Patient:</th>
</tr>
</thead>
</table>
New London Medical Group/NHC Patient Authorization

Patient Name: ________________________________ Date of Birth: ________________________________

I give the following person (s) permission to have access to:

Please check all that applies:

☐ Discuss only Medical Information (No release of medical records)
☐ Access to my Portal both Hospital and Medical Group
☐ Pick up Prescriptions

__________________________________________
Name

__________________________________________
Name

__________________________________________
Name

I have read the above and authorize the disclosure of the protected health information as stated.

__________________________________________
Signature of Patient/Guardian/Representative

__________________________________________
Date

Relationship to Patient

** Expires 1 year from date signed

Form# NLH1070
Revision Date: 3/14/2019
Originating Department: Medical Records
<table>
<thead>
<tr>
<th>Date</th>
<th>Script Name</th>
<th>Printed Name</th>
<th>Signature</th>
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<tbody>
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