~ ORCHARD MEDICAL GROUP ~

AUTHORIZATION TO REQUEST PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE FOLLOWING TO DISCLOSE THE PROTECTED HEALTH INFORMATION OF THE PATIENT LISTED BELOW. I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION COULD BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT, UNLESS PROHIBITED BY LAW.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE # _____ SS#: _____

NAME OF FACILITY OR PERSON THAT NOW HOLDS THE RECORDS:

ADDRESS: _____

PHONE #: _____ FAX #: _____

PLEASE TRANSFER RECORDS TO:

ORCHARD MEDICAL GROUP

_____ SALEM OFFICE -159 N. BROADWAY, Salem, NH 03079 - (PH) 603-693-4119
_____ HAMPSTEAD OFFICE - 207 Stage Rd, Hampstead, NH 01841 - (PH) 603-329-5222
FAX # 1-888-927-0461

REPORTS REQUESTED:

HISTORY AND PHYSICAL _____ OFFICE NOTES _____ _____
XRAY / DI REPORTS _____ _____ _____
LAB/PATHOLOGY _____ OTHER

ALL OF THE ABOVE ___✓____

HIGHLY CONFIDENTIAL INFORMATION:

MENTAL HEALTH _____ ALCOHOL/DRUG ABUSE _____
HIV/AIDS _____ SEXUALLY TRANSMITTED DISEASE _____
OTHER:

ALL OF THE ABOVE ___✓____

PURPOSE OF DISCLOSURE: MEDICAL CARE ____✓_____ OTHER_____

Note: This request will expire six months from request date, unless otherwise noted.

_____ Date: _____
Signature of Patient or Legal Representative

_____ _____
Name of Legal Representative Relationship to Patient

ORCHARD MEDICAL GROUP

PATIENT REGISTRATION FORM

Today's Date_____

Name: _____ Maiden Name: _____

Date of Birth: _____/_____ /_____ Marital Status: S M W D

Address:_____ City _____State _____ Zip Code_____

Home Telephone: _____Cell #_____Work # _____

Social Security # _____ - _____ - _____

E-Mail Address _____
Do you wish to join our Patient Portal to view medical records and receive appointment reminders? **YES / NO**

PRIMARY INSURANCE: _____

ID#_____ Group # _____

Subscriber's Name _____ DOB: _____

SECONDARY INSURANCE: _____ _____ ID# _____

PHARMACY - Local Name _____Address: _____

Mail Away (If applicable) _____ **PREFERRED LAB:**_____

CONSENT TO DISCUSS - May we share your healthcare with anyone other than yourself? YES / NO

Name of Recipient: _____Relationship: _____

PRIMARY LANGUAGE: _____ Decline to Answer: _____ ETHNICITY _____ Decline to Answer: _____

RACE: Caucasian ____ American Indian/Alaska Native ____ Asian____ Hispanic/Latino ____
Black/African American ____Native Hawaiian____ Other _____ Decline to Answer ____

EMERGENCY CONTACT:

NAME: _____ Relationship:_____

Home Telephone # _____ Work/Cell# _____

Information regarding the Health Insurance Portability & Accountability Act of 1996 (HIPAA) given upon request.

_____ _____

Signature Date

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

1, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Orchard all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance admissions.

_____ _____

Signature Date

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NEW PATIENT - MEDICAL HISTORY FORM

DATE: _____/_____/_____

Name: _____ Age _____ Birthdate ____/____/____

Address: _____ Sex: ◯ M ◯ F

_____ Home Phone: _____

_____ Work Phone: _____

Occupation: _____ Emergency Contact: _____

◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

If married, spouse's name _____

Children's names and ages _____

ALLERGIES TO MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES NO _____ YES _____

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation:_____Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

FAMILY MEDICAL HISTORY

_____ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer *(Type:*	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other_____	Other_____	Other_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	_____ Retired _____ Unemployed _____ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: Single _____Partner _____ Married _____Divorced _____Widowed _____ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day_____# of Years _____	***Past:*** Quit Date:_____Packs/day_____# of Years _____		
Other Tobacco *(check one)*: ____ Pipe ____ Cigar ____ Snuff ____ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	Beer / Wine / Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: o Male o Female		
Birth control method: _____None _____ Condom _____Pill/Ring/Patch/Injection/IUD _____Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.):_____How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? Good / Fair / Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

REVIEW OF SYSTEMS ✓ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
Activity change	Chest pain	Color change
Appetite change	Leg swelling	Pallor
Chills	Palpitations	Rash
Diaphoresis	**GASTRO-INTESTINAL**	Wound
Fatigue	Abdominal distention	**ALLERGY/IMMUNO**
Fever	Abdominal pain	Environmental Allergies
Unexpected weight change	Anal bleeding	Food allergies
HEAD, EAR, NOSE & THROAT	Blood in stool	Immunocompromised
Congestion	Constipation	**NEUROLOGICAL**
Dental problem	Diarrhea	Dizziness
Drooling	Nausea	Facial asymmetry
Ear discharge	Rectal pain	Headaches
Ear pain	Vomiting	Light-headedness
Facial swelling	**ENDOCRINE**	Numbness
Hearing loss	Cold intolerance	Seizures
Mouth sores	Heat intolerance	Speech difficulty
Nosebleeds	Polydipsia	Syncope
Postnasal drip	Polyphagia	Tremors
Rhinorrhea	Polyuria	Weakness
Sinus pressure	**Genitourinary**	**HEMATOLOGIC**
Sneezing	Difficulty urinating	Adenopathy
Sore throat	Dysuria	Bruises/bleeds easily
Tinnitus	Enuresis	**PSYCHIATRIC**
Trouble swallowing	Flank pain	Agitation
Voice change	Frequency	Behavior problem
EYES	Genital sore	Confusion
Eye discharge	Hematuria	Decreased concentration
Eye itching	Penile discharge	Dysphoric mood
Eye pain	Penile pain	Hallucinations
Eye redness	Penile swelling	Hyperactive
Photophobia	Scrotal swelling	Nervous/anxious
Visual disturbance	Testicular pain	Self-injury
RESPIRATORY	Urgency	Sleep disturbance
Apnea	Urine decreased	Suicidal ideas
Chest tightness	**MUSCULAR**	
Choking	Arthralgias	
Cough	Back pain	
Shortness of breath	Gait problems	
Stridor	Joint swelling	
Wheezing	Myalgias	
	Neck pain	
	Neck stiffness	