Dartmouth-Hitchcock

Complex Primary Care

Appointment/Transition of Care Request

100 Hitchcock Way,
Manchester, NH 03104
Phone: 603-695-2690
Fax: 603-727-7789

ALL HIGHLIGHTED ITEMS MUST BE COMPLETED

Today's Date: ____________________

❒ Male ❒ Female ❒ Non-binary DOB: ____________________

Patient's Name: Last: ____________________ First: ____________________ MI: ________

Address: ____

Home Phone: ____________________ Cell Phone: ____________________

Guardian Name: Last: ____________________ First: ____________________ Phone: ________

Caregiver Name: Last: ____________________ First: ____________________ Phone: ________

Language assistance needed: ❒ Patient ❒ Parent/Guardian Specify language: ____________________

Primary Diagnosis: ____

Referring Provider/Organization: ____ ❒ I am self-referring

Contact Name: ____

Office Phone: ____________________ Office Fax: ____________________

Address: ____

Primary Care Provider (if different from above): ____

Office Phone: ____________________ Office Fax: ____________________

Insurance: ____________________ Policy#: ____________ Group#: ____________

Insurance Address: ____ Subscriber#: ____________

Policy Holder Name: ____

Policy Holder DOB: ____________________ SS: ____________________

Please attach with this form guardianship/personal representative forms, updated problem list/diagnosis, medication and immunizations lists, and last physical notes. Fax documents to (603) 727-7789.