GRAND LAKE™
HEALTH SYSTEM

New Patient Packet Information:

We would like to take this opportunity to thank you for considering our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioners, nurses, medical assistants and office staff work closely in a "team approach" to support your patient care. We work collaboratively with Joint Township District Memorial Hospital and a wide range of specialists to coordinate all aspects of patient care including inpatient hospitalization and specialty consultation care, as needed.

Prior to establishing with a new GLPP primary care physician, you may be asked to contact your previous physician and request that a copy of your medical records be sent to the new office.

The enclosed forms will need to be completed and may need returned to the office prior to your appointment or brought with you to your appointment. If required, you will also need to notify your health insurance company of your new primary care provider. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. Please bring your health insurance identification card, photo I.D., and any medications (actual pill bottles) you are currently taking.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

Grand Lake Health System

GRAND LAKE HEALTH SYSTEM

PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ___/___/_____ RACE _____

PREFERRED LANG. ☐ ENG. OTHER _____ ETHNICITY _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

E-MAIL _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMPLOYER/OCCUPATION _____

REFERRING PHYSICIAN _____

FAMILY DOCTOR _____

EMERGENCY CONTACT

NAME _____ HOME PHONE _____

RELATIONSHIP WORK PHONE _____

IF MARRIED, SPOUSE INFORMATION

NAME _____ DATE OF BIRTH ___/___/_____ SSN _____

EMPLOYER _____ WORK PHONE _____

IF MINOR (UNDER THE AGE OF 18) WHO IS FINANCIALLY RESPONSIBLE? ☐ MOTHER ☐ FATHER

MOTHER'S NAME _____ FATHER'S NAME _____

ADDRESS _____ ADDRESS _____

_____ _____

SSN _____ DOB _____/_____/_____ SSN _____ DOB _____/_____/_____

EMPLOYER _____ EMPLOYER _____

WORK PHONE _____ CELL PHONE _____ WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Medicaid ☐ Medicare ☐ None ☐ Other INSURANCE COMPANY _____

INSURED'S NAME _____ RELATIONSHIP _____

DATE OF BIRTH ___/___/____ SSN _____ CO-PAY _____ POLICY NUMBER _____

SECONDARY INSURANCE INFORMATION

☐ Medicaid ☐ Medicare ☐ None ☐ Other INSURANCE COMPANY _____

INSURED'S NAME _____ RELATIONSHIP _____

DATE OF BIRTH ___/___/____ SSN _____ CO-PAY _____ POLICY NUMBER _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESSS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

The patient or representative, recognizing the need of medical care and/or evaluation, consents to services as ordered by the attending physician including local anesthesia, laboratory procedures, medical treatment, minor or emergency surgical treatment, radiology procedures, physical examination, or other services rendered under the general and specific instructions of the physician.

_____

SIGNATURE (Patient or Parent if Minor) DATE

GRAND LAKE™ HEALTH SYSTEM
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby authorize the use or release of personal health information about me as described below. I understand that copying charges may apply. (Copying charges are identified on the reverse side of this form.)

1. Information to be accessed or released: (check all that apply)
   - ☐ Discharge Summary
   - ☐ History & Physical
   - ☐ Consultation
   - ☐ Operative Report
   - ☐ Discharge Instruction Sheet
   - ☐ ER Chart
   - ☐ Urgent Care Chart
   - ☐ Laboratory Reports
   - ☐ Medical Imaging Reports
   - ☐ EKG
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ All Dictated Reports
   - ☐ Other (specify): _____

   From my visit of (Date of Service or Acct #): _____

2. My personal health information may be accessed or released to: _____
   - ☐ Mail copies of information
   - ☐ Pick up copies of information
   - ☐ Send summary of information
   - ☐ Inspect originals
   - ☐ Electronic copy
   - ☐ Fax copies of information to Healthcare Provider
   - ☐ Fax copies of Lab Results to Patient (Note: Confirm with patient that their fax machine is in a secure location) (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine). Patient Initials _____
   - ☐ Release Lab Results over the phone. Please provide a password _____ (GLHS is not responsible for unauthorized disclosure as a result of someone other than the patient calling to receive Lab Results over the phone with above identified password). Patient Initials _____

3. Purpose of the use or release:
   - ☐ Patient request
   - ☐ Marketing, if so remuneration to GLHS:
   - ☐ Other (describe): _____

4. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

5. I understand that the information in my health records may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

6. As described in the Notice of Privacy Practices of GLHS, I understand that I may revoke this authorization, except to the extent that action has been taken by GLHS in reliance on this authorization, by sending a written revocation to GLHS, 200 St. Clair Street, St. Marys, Ohio 45885: Attn: HIM.

7. This authorization is valid for 60 days, unless otherwise specified. ☐ 1 yr ☐ 5 yrs ☐ 10 yrs ☐ upon death

8. I understand that I am not required to sign this authorization form and that GLHS will not condition the provision of treatment or payment to me on the signing of this authorization. GLHS may condition the provision of health care to me that is solely for the purpose of creating protected health information for release to a third party on the signing of this authorization.

Patient Name (Print)	Identifier (Date of birth, service, etc.)
Legal Representative (Print)	Relationship (Parent, DPOA, Guardian)
Signature of Patient or Representative / Date	Employee Signature / Date

COPYING FEES

All other requests, i.e. attorney, insurance, etc.:

$ 19.58 record search fee.
$ 1.29 per page for first ten pages.
$ .66 per page for pages eleven through fifty.
$ .27 per page for pages fifty-one and higher.

Medical Images

$ 2.18 per page

GRAND LAKE™ HEALTH SYSTEM

NEW PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

YOUR ALLERGIES – please indicate reaction if there is a positive allergy:

☐ Dairy	☐ Tylenol	☐ Adhesive Tape	☐ Animal Dander
☐ Eggs	☐ Aspirin	☐ Cosmetics	☐ Dust
☐ Grains/Wheat	☐ Codeine	☐ Detergent	☐ Grass
☐ Nuts/Peanuts	☐ Sulfa Drugs	☐ Latex	☐ Insect bites/Stings
☐ Shellfish	☐ NSAIDS	☐ Metals	☐ Mites
☐ Strawberries	☐ Penicillin	☐ Molds/Mildew	☐ Pollen
			☐ Other

Please list any other allergies/reactions: _____

_____

_____

IMMUNIZATIONS:
Please attach or bring in a list of your immunization record.

YOUR MEDICAL HISTORY – Please check if you have any of these diagnoses:

☐ Alcohol Abuse	☐ Cancer type _____	☐ High Blood Pressure
☐ Anemia	☐ Depression	☐ High Cholesterol
☐ Arthritis	☐ Diabetes	☐ Liver Disease
☐ Asthma	☐ Drug Abuse	☐ Lung Disease
☐ Bleeding Disorders	☐ Epilepsy	☐ Mental Disorder
☐ Migraines	☐ Stroke	☐ Thyroid Disorder

Other medical problems: _____

_____

FAMILY MEDICAL HISTORY – please indicate who has this in your family (Mother, Father, Brother, Sister, Paternal Grandparent, Maternal Grandparent, Children)

Arthritis _____
Asthma _____
Bleeding Disorder _____
Cancers _____
Diabetes _____
Heart Disease _____
High Cholesterol _____
High Blood Pressure _____
Kidney Disease _____
Liver Disease _____
Mental Illness _____
Seizures _____
Alcohol Abuse _____
Drug Abuse _____
Thyroid Disorder _____
Tuberculosis _____
Birth Defects _____
Bed Wetting (over age of 10) _____
Genetic Disorders _____
Other _____

SURGICAL HISTORY
Please list all of your surgeries and the date they were done.

_____

_____

_____

_____

_____

YOUR SOCIAL HISTORY
Marital Status _____ Spouse Name: _____
Culture/Language _____
Living situation ☐ alone ☐ with spouse/partner ☐ with family ☐ Group Home ☐ Nursing Home
Occupation _____
Do you drink alcohol? ☐ YES ☐ NO
How much alcohol do you consume a week? _____
Do you smoke? ☐ YES ☐ NO
How much do you smoke? _____
Are you a former smoker? ☐ YES ☐ NO
How long did you smoke? _____
Do you have any tobacco smoke exposure? ☐ YES ☐ NO
How much caffeine do you drink daily? _____
If you have firearms in your home, do you keep them secured? ☐ YES ☐ NO ☐ Decline to answer
Do you have pets in the home? ☐ YES ☐ NO
Please list type of pets? _____

TRAVEL
What countries have you traveled to in the last 6 months? _____

YOUR PREGNANCY HISTORY?
How many times have you been pregnant? _____
Number of live births? _____
Number of living children? _____
Biggest babies weight? _____
Abortions? _____
Miscarriages? _____
Vaginal Deliveries? _____
C-Section Deliveries? _____
Premature Births? _____
Breech? _____

Do you perform your own self breast exams monthly: ☐ YES ☐ NO

Contraception History:
Are you currently sexually active? ☐ YES ☐ NO
How are you preventing pregnancy? _____
Are you interested in information on types of birth control? ☐ YES ☐ NO
Have you been exposed to any sexually transmitted infections? ☐ YES ☐ NO
If yes, please check:

☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ Syphilis ☐ Genital Herpes ☐ HIV

Menstrual History:
Last Menstrual Period (date): _____
Age cycles Began: _____
Length of Cycles (start to start, number of days): _____
How many days does the bleeding last: _____
Color: ☐ Bright Red ☐ Dark Brown
Menstrual Cycles: ☐ Regular ☐ Irregular
Type of flow: ☐ Light ☐ Moderate ☐ Heavy
Clotting: ☐ Rarely ☐ Frequently ☐ Occasionally
Mid Cycle Bleeding: ☐ YES ☐ NO
Age at Menopause: _____
Postmenopausal Bleeding: ☐ YES ☐ NO

YOUR MEDICATIONS
Please List or attach a copy of all of your current medications with dosages.

MEDICATION	DOSAGE

ADVANCE DIRECTIVES
Do you have a living will? ☐ YES ☐ NO
Do you have a healthcare Power of Attorney? ☐ YES ☐ NO
Are you an Organ Donor? ☐ YES ☐ NO
Do you have a DNR or DNRCC? ☐ YES ☐ NO
If yes to any of the above, are the documents on file at JTDMH? _____
_____
_____

PROVIDERS
Please list information for any other physicians you currently see: (*ex: Dr. Smith - Urologist, Celina, OH*)

_____
_____
_____
_____
_____
_____

GRAND LAKE™
HEALTH SYSTEM

OUR LOCATIONS

We're there, when you need us.

ST. MARYS

AUGLAIZE + MERCER GENERAL SURGERY

1140 S. Knoxville Avenue, Ste. C1
St. Marys, OH 45885
Phone: 419-394-9595
Fax: 419-394-9532
- **Lance Bryant, DO**
- **Krista Huber, PA-C**
- **Brittany Schlarman, APRN-CNP**

EMERGENCY CENTER AT JTDMH

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-394-3335
Fax: 419-394-9554

GRAND LAKE FOOT & ANKLE CENTER

1013 East Spring Street
St. Marys, OH 45885
Phone: 419-394-8664
Fax: 419-394-1148
- **Christopher Stucke, DPM**
- **Jennifer Oliver, APRN-CNP**

GRAND LAKE HEARTBURN CENTER

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-300-1135
Fax: 567-290-2166

GLHS INPATIENT PSYCHIATRIC SERVICES

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-394-9505
Fax: 419-394-9541

GRAND LAKE HOME HEALTH

1122 East Spring Street
St. Marys, OH 45885
Phone: 419-394-7434
Fax: 419-394-6503
Toll Free: 1-800-543-5115

GRAND LAKE HOSPICE

1122 East Spring Street
St. Marys, OH 45885
Phone: 419-394-7434
Fax: 419-394-6503
Toll Free: 1-800-543-5115
After Hours: 419-394-3335

GRAND LAKE NEUROLOGICAL CENTER

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-394-9522
Fax: 419-394-9523
- **Natasha Alexander, DO**
- **Katherine Zwiebel, APRN-CNP**

GRAND LAKE OB/GYN

1140 S. Knoxville Avenue, Ste. B
St. Marys, OH 45885
Phone: 419-394-7314
Fax: 419-394-7313
- **Polly Train, MD**
- **Whitney Clark, APRN-CNM**
- **Sara Gerlach, APRN-CNM**
- **Bridget Heckler, APRN-CNM**
- **Jackie Shriver, APRN-CNP**

GRAND LAKE OCCUPATIONAL MEDICINE

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-394-3335
Fax: 419-394-9556
- **Juan Torres, MD**

GRAND LAKE PEDIATRICS

1010 Hager Street
St. Marys, OH 45885
Phone: 419-394-9579
Fax: 419-394-9580
- **Efren Aganon, MD**
- **Alexander Mast, DO**
- **Thomas Zegarski, MD**

GRAND LAKE PEDIATRIC REHAB

1040 Hager Street
St. Marys, OH 45885
Phone: 419-300-1140
Fax: 567-290-2228

GRAND LAKE PRIMARY CARE AT ST. MARYS

1140 S. Knoxville Avenue, Ste. A
St. Marys, OH 45885
Phone: 419-394-9959
Fax: 419-394-0255
- **Padmaja Chalasani, MD**
- **Andrea Gonzalez, MD**
- **Michael Josey, MD**
- **Dawn McNaughton, MD**
- **Nicole Link, APRN-CNP**
- **Jayaben Patel, APRN-CNP**

GRAND LAKE REHAB & WELLNESS CENTER

1065 Hager Street
St. Marys, OH 45885
Phone: 419-394-9514
Fax: 419-394-0883

GRAND LAKE SLEEP CENTER

975 Hager Street
St. Marys, OH 45885
Phone: 419-394-9992
Fax: 419-394-9629
- **Jennifer Nyitray, PA-C**

GRAND LAKE UROLOGY

1140 S. Knoxville Avenue, Ste. C2
St. Marys, OH 45885
Phone: 419-394-0326
Fax: 419-464-7083
- **Omar Khan, MD**
- **Hesham Mostafa, MD**
- **Daniel Murtagh, Jr. MD**
- **Holly Borchers-Ellinger, APRN-CNP**

GRAND LAKE WOUND CARE CENTER

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-394-9512
Fax: 419-394-9589

JOINT TOWNSHIP DISTRICT MEMORIAL HOSPITAL

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-394-3335
Toll Free:1-877-564-6897

NEW DAY PAIN MANAGEMENT CENTER

1165 S. Knoxville Avenue, Ste.105
St. Marys, OH 45885
Phone: 419-394-9520
Fax: 419-394-9598
- **Amber Ball, APRN-CNP**

URGENT CARE AT JTDMH

200 St. Clair Street
St. Marys, OH 45885
Phone: 419-394-3335

1.11.24

GRAND LAKE™
HEALTH SYSTEM

CELINA

AUGLAIZE + MERCER GENERAL AND BARIATRIC SURGERY

801 Pro Drive
Celina, OH 45822
Phone: 419-586-6480
Fax: 419-586-8574
- **James Reichert, DO**
- **Deanna Bruggeman, APRN-CNP**
- **Kevin Dirksen, APRN-CNP**
- **Lindsey Moeller, APRN-CNP**

CIAO! MED SPA

123 Hamilton Street
Celina, OH 45822
Phone: 419-586-2426
Fax: 419-586-7179

GRAND LAKE FAMILY PRACTICE & PEDIATRICS

801 Pro Drive
Celina, OH 45822
Phone: 419-586-6489
Fax: 419-586-8509
- **Andrea Gonzalez, MD**
- **Kevin Jackson, PA-C**

GRAND LAKE PEDIATRICS

801 Pro Drive
Celina, OH 45822
Phone: 419-394-9579
Fax: 419-394-9580
- **Alexander Mast, DO**

GRAND LAKE FOOT & ANKLE CENTER

123 Hamilton Street
Celina, OH 45822
Phone: 419-394-8664
Fax: 419-394-1148
- **Christopher Stucke, DPM**
- **Jennifer Oliver, APRN-CNP**

GRAND LAKE OB/GYN

801 Pro Drive Ste. D3
Celina, OH 45822
Phone: 419-394-7314
Fax: 419-394-7313
- **Whitney Clark, APRN-CNM**

KEMMLER ORTHOPAEDIC CENTER

123 Hamilton Street
Celina, OH 45822

140 Fox Road, Ste. 209
Van Wert, OH 45891
Phone: 419-586-5760
Fax: 419-586-7179
- **James Kemmler, MD**
- **Jed Kohne, PA-C**

MOR REHAB

123 Hamilton Street
Celina, OH 45822
Phone: 419-586-9300
Fax: 419-394-9528

VANAN ENT & SINUS CENTER

801 Pro Drive
Celina, OH 45822
Phone: 419-586-6480
Fax: 419-586-4125
- **Suri Vanan, MD**
- **Andrew Klausing, PA-C**
- **Heather Ott, APRN-CNP**

COLDWATER

AUGLAIZE + MERCER GENERAL SURGERY

830 W. Main Street Ste. E1A
Coldwater, OH 45828
Phone: 419-394-9595
Fax: 419-394-9532
- **Lance Bryant, DO**
- **Krista Huber, PA-C**
- **Brittany Schlarman, APRN-CNP**

AUGLAIZE + MERCER GENERAL AND BARIATRIC SURGERY

830 W. Main Street Ste. E1A
Coldwater, OH 45828
Phone: 419-586-6480
Fax: 419-586-8574
- **James Reichert, DO**
- **Deanna Bruggeman, APRN-CNP**
- **Kevin Dirksen, APRN-CNP**
- **Lindsey Moeller, APRN-CNP**

MARIA STEIN

MARIA STEIN FAMILY PRACTICE

8381 State Route 119
Maria Stein, OH 45860
Phone: 419-925-4613
Fax: 419-925-4168
- **James Schwieterman, MD**

MINSTER

MIAMI & ERIE FAMILY PRACTICE & PEDIATRICS

04463 State Route 66
Minster, OH 45865
Phone: 419-628-3821
Fax: 419-628-9501
- **Olubukola Adelola, MD**
- **James Luedeke, MD**
- **Sarah Werner, DO**
- **Sara Hess, APRN-CNP**

WAPAKONETA

GRAND LAKE PEDIATRICS

812 Redskin Trail Ste. B-1
Wapakoneta, OH 45895
Phone: 419-394-9579
Fax: 419-394-9580
- **Thomas Zegarski, MD**

WAPAKONETA PRIMARY CARE

812 Redskin Trail, Ste. A
Wapakoneta, OH 45895
Phone: 419-738-4445
Fax: 419-738-4601
- **V.K. Chalasani, MD**

VANAN ENT & SINUS CENTER

812 Redskin Trail Ste. B-2
Wapakoneta, OH 45895
Phone: 419-586-6480
Fax: 419-586-4125
- **Suri Vanan, MD**
- **Andrew Klausing, PA-C**
- **Heather Ott, APRN-CNP**