GRAND LAKE™
HEALTH SYSTEM

New Patient Request Form

Patient Name _____ DOB _____

Previous Healthcare Provider(s) _____

Reason for Transfer _____

_____

New Patient papers mailed/picked up - ☐ YES or ☐ NO Date _____

New Patient papers received back - ☐ YES or ☐ NO

Date Transfer/Record Request Received _____

Date Record Request Faxed _____

OARSS Attached ☐ YES or ☐ NO

Records in System for Review ☐ YES or ☐ NO

Doctor Signature _____

Patient Accepted ☐ YES or ☐ NO or ☐ Need Full Record

Appointment Length _____ minutes

Reason for Denial:

Better fit elsewhere ☐

Other_____

Patient notified of Decision - ☐ YES or ☐ NO

New Patient Establish Appt Scheduled - ☐ YES or ☐ NO Appt. Date _____

Date Records Received _____

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

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, Children Paternal Grandmother, Paternal Grandfather or Maternal Grandmother, Maternal Grandfather)

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 FAMILY PRACTICE AND PEDIATRICS™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM
801 Pro Drive, Celina, OH 45822
Phone: 419.586.6489
Fax: 419.586.8509
WWW.GRANDLAKEHEALTH.ORG

Patient Name: _____

Consent for Notification

1. If we call you at home and you are not available, may we leave information such as positive/negative test results, appointments, billing matters and health care information with another person?

   _____YES _____NO

   If YES, please state name of person (s) and relationship:

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

2. If you have an answering machine at home, may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your answering machine does not identify yourself, we will not leave a detailed message.

   _____YES _____NO

3. If you have a cell phone may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your cell phone voice mail does not identify yourself, we will not leave a detailed message.
   ** I am fully aware that a cellular telephone is not a secure line and private line.

   _____YES _____NO

If the above answers are NO, how is the best way to contact you? _____

_____
Patient Name (Please PRINT)

_____ _____ _____
Patient Date of Birth Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:_____

This Authorization is valid until you inform our office otherwise in writing.

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	☐ ER Chart	☐ Physician Orders
☐ History & Physical	☐ Urgent Care Chart	☐ Progress Notes
☐ Consultation	☐ Laboratory Reports	☐ All Dictated Reports
☐ Operative Report	☐ Medical Imaging Reports	☐ Other (specify):
☐ Discharge Instruction Sheet	☐ EKG	___
		___
		___

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.:

$ 22.25 record search fee.
$ 1.53 per page for first ten pages.
$ .79 per page for pages eleven through fifty.
$ .31 per page for pages fifty-one and higher.

Medical Images

$ 2.48 per page