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 _____

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

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

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]
   - ☐ Yes
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[4]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

GRAND LAKE
PHYSICIAN PRACTICES

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

WAPAKONETA PRIMARY CARE™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Prescription Refill Policy and Renewal Guidelines for Grand Lake Physician Practice Offices

Prescription medication requires skilled oversight by a licensed healthcare provider. It also requires the patient to have an awareness of what they are taking, how they take it and any noticeable effect it may have on their person.

In order to ensure that you have current and adequate medication, we are asking that you participate in your care by doing the following:

1. Before your appointment, gather all your medications (diabetic supplies, inhalers, etc.) and look at the number of pills and date of refill. Make a note of any that need to be addressed at your visit and point that out to our nurse when she is talking to you about your medication history.
2. Bring all of your prescription bottles with you to your appointment. This is important as it helps us make sure our records match what you are currently taking. We will match the medication and doses to our records and address any differences that we find. It is very important that if you are cutting any of your pills in half or otherwise changing the amount taken compared to what is prescribed that you let us know for your safety.
3. For your safety, we require regular office visits for all our patients taking prescription medication. It is VERY important that you come to these appointments and that you follow up with all requested lab or other testing. It is also important for your safety that you limit the number of pharmacies where you fill your prescriptions. This allows the pharmacist to be alert for potential drug interactions and helps them ensure you have the right medication for you. For these reasons, we will handle refill requests as follows:
   - ✓ We ask that you limit yourself to no more than one local and one mail-in pharmacy service.
   - ✓ We can send most prescriptions electronically to the local pharmacy of your choice (you will need to let the nurse know what pharmacy you prefer to work with). Generally it is best to call your pharmacy to see when your prescription will be ready, that way you will not have to wait too long when you get there.
   - ✓ We can send prescriptions electronically to a mail-order pharmacy. You need to have an account set up with the mail-order pharmacy for us to do this.
   - ✓ We can provide electronically written prescriptions. This will be on a very limited basis.
   - ✓ Prescriptions for certain narcotics or attention deficit disorders medication **must be picked up at our office**. These medications will be monitored to make sure you are taking them correctly; this is required by the new state laws.

Our new policy will be to send in appropriate requests for prescription refills **within 2 business days**. Written prescriptions will be available for pickup within 2 business days. Please let our staff know if your request is urgent or if you are out of medication, in which case we will try to try to provide refills sooner.

_____
Initials

WAPAKONETA PRIMARY CARE™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM
812 Redskin Trail, Wapakoneta, OH 45895
Phone: 419.738.4445
Fax: 419-738-4601
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? _____

_____

Please PRINT Name

_____ _____ _____

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

Patient Portal Account Access Form

Thank you for your interest in the FollowMyHealth patient portal, made available by Grand Lake Health, to provide a convenient and secure way for patients to manage their personal health record from any computer or mobile device with internet access.

Instructions for Completing this Form

To sign up for access to your health information in FollowMyHealth, please complete this Access Form. You will receive an email with an invitation to join FollowMyHealth and step by step instructions to complete the process. A separate form will need completed for each patient requesting/granting access.

Your Information: (All sections required in order to receive an invitation – please print clearly.)

Patient Name: _____ Patient Birth Date ____ /____ /____ Sex: M □ F□

Patient Address: _____
(Street) (City) (State) (Zip Code)

Patient Phone:_____ Patient Email: _____

ACCESS TYPE
□ **Minor child Proxy (age 13 or younger) –** must have authorization signed by parent/legal guardian
□ **Minor child Proxy (age 14 to 17) –** must have authorization signed by patient (minor patient) • **for parent or legal guardian** □ **I grant full access** □ **I grant the standard limited access**
□ **Minor personal access (age 14 to 17) –** must have authorization signed by patient (minor patient) • **for patient's personal access**
□ **Adult Proxy (age 18+) –** must have authorization signed by patient • **for adult to grant another individual full access to their portal**
□ **Adult Personal Access (age 18+) –** Simply provide email address at time of check-in/registration – OR have authorization signed by patient.
To have access granted to the patient portal return this Patient Portal Account Access Form to one of the following: Grand Lake physician practice, medical records department at JTDMH or fax to 419-394-3692

INFORMATION FOR PROXY REQUESTING ACCESS (Proxy access is providing access to your patient information on the FollowMyHealth patient portal to someone other than yourself)

Proxy Name: _____ Proxy Birth Date ____ /____ /____

Proxy Address: _____
(Street) (City) (State) (Zip Code)

Proxy Phone:_____ Proxy Email: _____

Relationship to Patient: □ Mother □ Father □ Spouse □ Guardian □ POA □ Attorney □ Other

AUTHORIZATION: Permission is hereby granted to Grand Lake Health to release medical information via the Grand Lake Health FollowMyHealth® Patient Portal, to the individual as identified above.

Responsible Party Signature: _____ Date:_____

Relationship to patient: □ Self □:_____

FOR INTERNAL USE ONLY

□ Reviewed and verified form. _____ initials Patient MRN:_____

□ Access initiated in EHR_____ initials □ Form sent for scanning into EHR _____ initials