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 _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

FATHER'S NAME _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURED'S NAME _____

DATE OF BIRTH ___/___/___ SSN _____

INSURANCE COMPANY _____

RELATIONSHIP _____

CO-PAY _____ POLICY NUMBER _____

SECONDARY INSURANCE INFORMATION

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURED'S NAME _____

DATE OF BIRTH ___/___/___ SSN _____

INSURANCE COMPANY _____

RELATIONSHIP _____

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
PHYSICIAN PRACTICES™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	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

For office coding: _____0_____+_____+_____+_____+_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

PP-437pc 10/20

MIAMI & ERIE FAMILY PRACTICE & PEDIATRICS™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

04463 St. Rt. 66N
Minster, OH 45865
Phone: 419.628.3821
Fax: 419.628.9501

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
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

GLHS recognizes a patient's right of access under HIPAA.

Patient Name: _____ Patient Date of Birth: _____

1. Request access for Dates of Service:_____
   OR ☐ Any and All Past, Present and Future information (until revoked in writing)

2. Information to be accessed or released: (check ONLY ONE box below)
   ☐ ALL Grand Lake Health System Records: Joint Township District Memorial Hospital (JTDMH) and all Physician Practice records
   ☐ Joint Township District Memorial Hospital records ONLY (this includes ER, Inpatient, Urgent Care, Outpatient testing, Outpatient Services, Rehab/Therapy, Outpatient Clinics (Pain/Sleep/IV, etc)
   ☐ ONLY specific portions of the JTMDH record:
   - ☐ Discharge Summary
   - ☐ History & Physical
   - ☐ Consultation
   - ☐ Operative Report
   - ☐ Discharge Instruction Sheet
   - ☐ ER Chart
   - ☐ Urgent Care Chart
   - ☐ Laboratory Reports
   - ☐ Medical Imaging Reports/CD Images
   - ☐ EKG
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ All Dictated Reports
   - ☐ Other (specify): _____

   ☐ ALL Grand Lake Physician Practice Records (ALL Offices, including family practice and specialty)
   ☐ ONLY records from specificPhysician Practice Office; Office Name:_____

3. Requestor: (check one)☐ Self (Patient) ☐ Patient Representative; Name _____
   IF Patient Representative, check one below AND validate parent OR documents
   ☐Parent/Guardian ☐HPOA ☐Executor of Estate ☐Other: _____

4. How would you like record copies delivered? (check all that apply)
   ☐ Paper Copy ☐ Electronic Copy via USB/Flash Drive (ONLY on device supplied by GLHS)
   ☐ In-Person Pickup (self)
   ☐ Allow someone else to pick up my records; Name: _____
   ☐ Mail Delivery; Street Address: _____
   City/State/Zip: _____

   Miami & Erie Family Practice & Pediatrics
   James Luedeke, MD
   Sarah Werner, DO
   Olubukola A. Adelola, M.D.
   Sara Hess, NP-C
   04463 State Route 66N • Minster, OH 45865

   ☐ Email Copy; email address: _____ * NOTE: EMAIL is NOT a secure method of sending medical information. I understand I am requesting my information to be sent in a non-secure method. _____ (patient initials)

   ☐ Fax copies 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 _____

_____ _____
Signature of Patient or Representative Date

For Internal use only:

Patient MRN #:	*Patient Visit #:*	
Date Requested:	*Date Completed:*	*Completed By:*

GRAND LAKE HEALTH SYSTEM

Welcome to FollowMyHealth

DO NOT use FollowMyHealth for medical emergencies. If you feel you have a medical emergency, please seek care immediately or call 911 as appropriate.

Grand Lake Health System offers FollowMyHealth, a web-based and mobile resource for patients, to access medical information for you, your child, or adult family member. This tool is available for both physician practice and hospital patients and some of the features include:

- View the health summary
- Download your health record
- Request medical appointments with your care team
- Communicate electronically and securely with your medical care team
- View test results
- View medications on file
- Prescription renewals - make a request in your FollowMyHealth account under:
  - My Health > Medications
- View allergies and immunizations on file
- View details about past appointments and hospital admissions
- Receive email and/or text reminders of up-coming appointments

How do I sign up for FollowMyHealth?

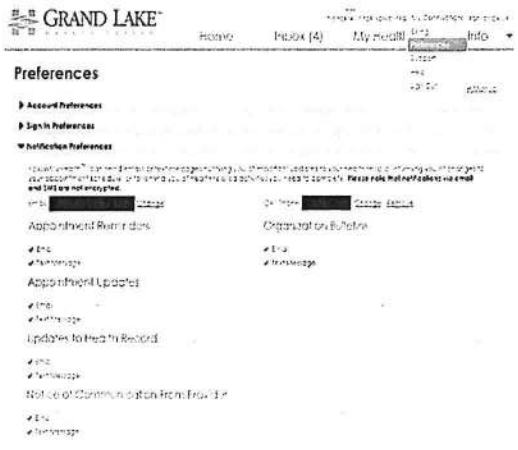
1. Provide an email at your physician practice appointment or at the time of hospital registration. Patients may complete the Patient Portal Account Access Form if an email is not initially available.
2. Our staff will send you an email with a FollowMyHealth Invitation Code along with signup instructions. Click the link within the email to proceed to the sign up page.

Who can have access to FollowMyHealth?

- If you are a patient and over 14 years old, you may request an activation code for yourself.
- Minor patients older than age 14 and adult patients can grant proxy access to another individual. Patient can request the Patient Portal Account Access Form to grant this access.
- Parents or guardians of the minor child (under 14 years of age) have full access to the minor's information until the minor is the age of 14. After age 14, parents have limited access (Per Ohio Revised Code). At age 18 the proxy access is automatically terminated.
- Parents can access the medical records of all family members seen at Grand Lake Health System from one "proxy" account.

Change Communication Settings in the desktop or App version:

Go to My Account
(top right of page)
Preferences
Notification
Preferences



- Go to Device Settings
- Notifications
- Push Settings

GRAND LAKE™
HEALTH SYSTEM

CELINA

AUGLAIZE + MERCER GENERAL AND BARIATRIC SURGERY

801 Pro Drive, Ste. D2
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

GRAND LAKE FAMILY PRACTICE & PEDIATRICS

801 Pro Drive, Ste. D1
Celina, OH 45822
Phone: 419-586-6489
Fax: 419-586-8509
- **Andrea Gonzalez, MD**
- **Kathryn Bruns, APRN-CNP**
- **Kevin Jackson, PA-C**

GRAND LAKE PEDIATRICS

801 Pro Drive, Ste. D5
Celina, OH 45822
Phone: 419-394-9579
Fax: 419-394-9580
- **Alexander Mast, DO**

GRAND LAKE FOOT & ANKLE CENTER

123 Hamilton Street, Ste. B
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, Ste. A
Celina, OH 45822

140 Fox Road, Ste. 102
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, Ste. D4
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**
- **Katie Heitkamp, APRN-CNP**

MINSTER

MIAMI & ERIE FAMILY PRACTICE & PEDIATRICS

04463 State Route 66, Ste. A
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. B1
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. B2
Wapakoneta, OH 45895
Phone: 419-586-6480
Fax: 419-586-4125
- **Suri Vanan, MD**
- **Andrew Klausing, PA-C**
- **Heather Ott, APRN-CNP**

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, Ste. 101
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**
- **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