GRAND LAKE™
HEALTH SYSTEM

Dear Patient,

Thank you for choosing our physicians to be a part of your healthcare journey. We are committed to providing you with personalized, comprehensive care that emphasizes wellness and preventive health. Our approach is rooted in continuity and coordination to ensure all your healthcare needs are met effectively.

We work closely with Joint Township District Memorial Hospital, as well as a wide network of specialists, to coordinate all aspects of care, including inpatient hospitalizations and specialty consultations when necessary. Before your first visit with a Grand Lake primary care provider (GLPP), you may be asked to request that your medical records be transferred from your previous physician to our office.

Enclosed you will find several forms to complete. These can be returned to our office prior to your appointment or brought with you on the day of your visit. Please also be sure to notify your health insurance provider of your new primary care physician to verify that we are in-network according to your plan.

For your appointment, please bring the following:

- Your health insurance ID card
- A valid photo ID
- All current medications in their original containers
- Arrive 15 minutes early to your appointment time

We appreciate the opportunity to serve as your primary healthcare provider and look forward to partnering with you in maintaining your health.

Warm regards,

Grand Lake Health System

200 ST. CLAIR STREET | ST. MARYS, OHIO 45885-2400
PHONE 419-394-3335 | TOLL-FREE 877-564-6897 | WWW.GRANDLAKEHEALTH.ORG

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

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION TO SOMEONE OTHER THAT THE PATIENT OR PATIENT REPRESENTATIVE

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.)

Patient Name: _____ **Patient Date of Birth:** _____

1. Information to be accessed or released: (***check ONLY ONE box*** below)

☐ **ALL Grand Lake Health System Records**: This includes BOTH Joint Township District Memorial Hospital (JTDMH) AND Grand Lake Physician Practice (GLPP) records

OR

☐ **ONLY Hospital Records (Joint Township District Memorial Hospital)**

- ☐ All portions of the hospital record
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Operative Report
- ☐ Discharge Instruction Sheet
- ☐ ER Chart
- ☐ Urgent Care Chart
- ☐ Laboratory Reports
- ☐ Medical Imaging Reports/CD Images
- ☐ EKG
- ☐ Rehab/Therapy
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Physician Reports
- ☐ Pain Clinic
- ☐ Other (specify): _____

OR

☐ **ONLY Grand Lake Physician Practice Records**

- ☐ All Physician Practices
- ☐ Specific Office/Provider: _____

2. Dates of Service to Release: _____

3. My personal health information may be accessed or released to: _____

- ☐ Mail paper copies of information
- ☐ Mail electronic copies of information
- ☐ Fax copies of information

4. Purpose of the use or release:

- ☐ Personal Use
- ☐ Attorney
- ☐ Another Healthcare Provider
- ☐ Insurance
- ☐ Workers Comp/Employer
- ☐ Other (describe): _____

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

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.

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.

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.

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

GRAND LAKE™
HEALTH SYSTEM

At Grand Lake Health System we believe that everyone should have a fair and just opportunity to be healthier. Please take the time to help us understand more about who you are, so we can give you the highest quality care.

Race: Do you identify with a specific racial group? This information helps us understand health disparities and tailor care.

- o White
- o Pacific Islander
- o African American
- o 2 or more races
- o Asian
- o Hispanic
- o Native American
- o Other
- o Prefers not to Answer

Ethnicity: Do you identify with a specific ethnic group? This information helps us understand health disparities and tailor care.

- o Not Hispanic Latino
- o Hispanic Latino
- o Undisclosed
- o Prefers not to answer

Preferred Language: What language do you prefer for communication? Ensuring language access is crucial.

- o _____
- o Interpreter required.
- o Prefers not to Answer

Language Ability (For Those Who are Hearing and/ or Verbally Impaired):

- o Expressed Signed
- o Received Signed
- o Expressed Spoken
- o Received Spoken
- o Expressed Written
- o Received Written

Gender Assigned at Birth: This helps us address gender-specific health needs.

- o Male
- o Female
- o Prefers not to Answer

Gender Identity: How do you identify? This helps us address gender-specific health needs.

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HEALTH SYSTEM

At Grand Lake Health System we believe that everyone should have a fair and just opportunity to be healthier. Please take the time to help us understand more about who you are, so we can give you the highest quality care.

- Transgender Female (Male to Female)
- Transgender Male (Female to Male)
- Other
- Prefers not to Answer

Sexual Orientation: Would you like to share your sexual orientation? It helps us provide culturally competent care.

- Straight or heterosexual
- Something else please describe _____
- Bisexual
- Don't know.
- Lesbian, Gay, or Homosexual
- Prefer not to answer.

Religious Preferences: Do you have any religious or cultural preferences related to care?

- Baptist
- Catholic
- Methodist
- Protestant
- Other_____
- None
- Prefers not to answer.

Disability Status: Do you have any disabilities or accessibility needs?

- Hearing Impaired
- Legally Deaf
- Vision Impaired
- Legally Blind
- Memory Concerns
- Ambulation Issues
- Independence Issues
- Prefer not to Disclose

Is there anything else about you we should know to treat you?

- _____
  _____
  _____

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**
- **Amanda Perry, APRN-CNP**
- **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**
- **Jessica Wuebker, 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

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**
- **Logan Ridenour, 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

- **Syed Ali, MD**
- **Amber Ball, APRN-CNP**

URGENT CARE AT JTDMH

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

5.9.25