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: _____
Phone Number: _____ Email: _____

GENERAL INFORMATION

Relationship Status: ☐ Single ☐ Committed Relationship ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Employment Status: ☐ Unemployed ☐Employed ☐ Retired ☐ Student ☐ Other: _____
Primary Caregiver: ☐ Self ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Other: _____
Significant Exposure to Hazardous Materials: ☐ Yes ☐ No
If yes, please specify: _____
Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Marshallese ☐ Other: _____
Preferred Reading Language: ☐ English ☐ Spanish ☐ Marshallese ☐ Other: _____

ALLERGIES

☐ No Known Drug Allergies ☐ Latex Allergy
Please list allergies and describe the reactions: _____
_____
_____
_____
_____
_____

LIVING ENVIRONMENT

Lives with: ☐ Private Residence ☐ With Family ☐ Assisted Living Facility ☐ Other: _____
Living Arrangements: ☐ Apartment ☐ Assisted Living ☐ Condominium ☐ Extended Care ☐ Homeless/shelter ☐ Home with Home Health ☐ Hospice Care Facility ☐ House ☐ Mobile Home ☐ Other: _____
Travel History in the last 6 months: ☐ Yes ☐ No
If yes, where to? _____

EXERCISE HISTORY

Lifestyle Lead: ☐ Active ☐ Sedentary
Exercises Regularly: ☐ Yes ☐ No

SOCIAL HISTORY:

Cigarette Use:

Cigarette Smoking Status: ☐ Current every day smoker ☐ Former smoker ☐ Never Smoker
Cigarettes Smoked per Day (# packs): _____
Length of Cigarette Use (years): _____

Other Tobacco Use:

Other Tobacco use status: ☐ Current ☐ Past ☐Never
Current Other Tobacco use: ☐ Chewing tobacco ☐ Cigar ☐ Pipe ☐ Vaping

Caffeine Use:

Caffeine Use: ☐ Caffeine use currently ☐ Does not use caffeine
Caffeine Type: ☐ Coffee ☐ Tea ☐ Pop/Soda ☐ Energy Drink

Caffeine Amount: ☐ 1-2 cups/cans per day ☐ 3-4 cups/cans per day ☐ 5-6 cups/cans per day ☐ 7-9 cups/cans per day ☐ 10 or more cups/cans per day

Alcohol Use:

Alcohol Use Status: ☐ Alcohol currently ☐ Alcohol past ☐ Alcohol never used

Alcohol Amount: ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks

Alcohol Frequency: ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week ☐ Daily

Alcohol Type: ☐ Beer ☐ Wine ☐ Liquor

Alcohol Duration: _____

Family History of Alcohol Abuse: ☐ No ☐ Yes-see Family History in Health Issues ☐ Unknown-adopted

Street Drug Use:

Street Drug/Inhalant/Medication Use Status: ☐ Current use ☐ Past use ☐ Never used

Street Drug/Inhalant/Medication Type: ☐ Amphetamines ☐ Cocaine ☐ Depressants ☐ Ecstasy ☐ Hallucinogens ☐ Heroin ☐ Inhalants (solvents, gases, nitrate, aerosols) ☐ Marijuana ☐ Mescaline ☐ Methamphetamine ☐ Narcotics ☐ PCP (Phencyclidine) ☐ Sedatives ☐ Steroids ☐ Stimulants

Route: ☐ Intravenous ☐ Oral ☐ Smoking ☐ Snorting

Duration: _____

Frequency: ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week ☐ Daily

Family History of Drug Abuse: ☐ No ☐ Yes-See Family History in Health Issues ☐ Unknown-adopted

MENTAL HEATLH:

Personal History OF Mental Illness/Depression/Behavioral Health Issues: ☐ No ☐ Yes-see Health Issues

Family History of Mental Illness/Depression/Behavior Health Issues: ☐ No ☐ Yes-see Family History in Health Issues ☐ Unknown-adopted

Sexual and Contraceptive History:

Sexual History: ☐ Never ☐ Active ☐ Not Currently Active

Sexual Partner: ☐ Single partner ☐ multiple partners ☐ Male ☐ Female

Contraception Method: ☐ None ☐ Condom ☐ Contraceptive Injections ☐ other Barrier methods ☐ Hysterectomy ☐ IUD ☐ Oral Contraceptives ☐ Menopause ☐ Partner had vasectomy ☐ Rhythm Method ☐ Tubal ligation ☐ Withdrawal Method ☐ Long term reversible contraception

Sexual Transmitted Infection Past History: ☐ None ☐ Yes

If yes, please indicate which sexual transmitted infection: ☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ Syphilis ☐ Genital Herpes ☐ HIV

Menstrual History:

Last Menstrual Period (LMP): _____ ☐ Have not had a 1st period yet **Pregnant:** ☐ Yes ☐ No ☐ Not Applicable

Age at Menarche: _____

Menstrual Cycle Duration (days): _____

Color: ☐ Bright red ☐ Dark Brown

Bleeding: ☐ Light ☐ Normal ☐ Heavy

Clots: ☐ Rarely ☐ Frequently ☐ Occasionally

Age at Menopause: _____

Post Menopausal Bleeding: ☐ Yes ☐ No

HPV Positive: ☐ Yes ☐ No **Pregnancy:**

How many pregnancies: _____ How many live births: _____

How many miscarriages: _____ How many abortions: _____

PAST MEDICAL HISTORY *(Please select all conditions that you have or have had)*

☐ None	☐ Anemia	☐ Anxiety	☐ Arthritis
☐ Arrhythmia/Atrial Fibrillation	☐ Asthma	☐ COPD/Emphysema	☐ Dementia/Alzheimer
☐ Depression	☐ Diabetes Type 1	☐ Diabetes Type 2	☐ Heart Disease/Heart Attack
☐ High blood pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Hyperthyroidism/Graves

☐ Hypothyroidism ☐ Mental Illness ☐ Kidney Stones ☐ Migraines
☐ Osteoporosis ☐ Seizures ☐ Sleep Apnea ☐ Stomach Ulcer
☐ Stroke/TIA ☐ Cancer:
Type: _____ Date: _____ Treatment: _____
☐ Cancer:
Type: _____ Date: _____ Treatment: _____
☐ Cancer:
Type: _____ Date: _____ Treatment: _____
☐ List other medical conditions not listed above: _____
_____
_____
_____

FAMILY MEDICAL HISTORY

Mother: ☐ Living ☐ Deceased Age: _____
Medical history or Cause of Death:
☐ High blood pressure ☐ Diabetes ☐ Cholesterol ☐ Heart Disease
☐ Cancer: Type _____
☐ Other conditions not listed:
_____ **Father:** ☐ Living ☐ Deceased Age: _____
Medical history or Cause of Death:
☐ High blood pressure ☐ Diabetes ☐ Cholesterol ☐ Heart Disease
☐ Cancer: Type _____
☐ Other conditions not listed:
_____ **Brothers:** # Living _____ # Deceased _____ Ages: _____ Medical history or Cause of Death:
☐ High blood pressure ☐ Diabetes ☐ Cholesterol ☐ Heart Disease
☐ Cancer: Type _____
☐ Other conditions not listed:
_____ **Sisters:** # Living _____ # Deceased _____ Ages: _____ Medical history or Cause of Death:
☐ High blood pressure ☐ Diabetes ☐ Cholesterol ☐ Heart Disease
☐ Cancer: Type _____
☐ Other conditions not listed:
_____ **Other Relatives:**
Relation: _____ Age: _____ Medical Condition: _____
Relation: _____ Age: _____ Medical Condition: _____
Relation: _____ Age: _____ Medical Condition: _____

SURGICAL HISTORY

Please list all your surgeries and the date they were done.
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____

Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____
Date: _____ Type of Surgery: _____ Name of Surgeon: _____ Facility: _____

Hospitalization other than Surgical and Childbirth:

Date: _____ Facility: _____ Reason: _____
Date: _____ Facility: _____ Reason: _____
Date: _____ Facility: _____ Reason: _____

YOUR MEDICATIONS

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

PRESCRIPTION NAME	DOSAGE	FREQUENCY	PRESCRIBED BY

NON-PRESCRIPTION MEDICATIONS (*over the counter, supplements, and herbs)*

NAME	DOSAGE	FREQUENCY

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? _____

_____

PREVENTATIVE HEALTH SCREENINGS

Date of last eye exam: _____
Date of last PAP smear: _____
Date of last Mammogram: _____
Date of last Bone Density scan: _____
Date of last PSA: _____
Date of last Colon Cancer screening: _____
☐ Colonoscopy ☐ Cologuard ☐ Fecal occult blood stool ☐ CT Colonography ☐ Flexible Sigmoidoscopy
Results: _____

IMMUNIZATIONS

Influenza Date: _____
Pneumonia Date: _____
Tetanus Date: _____
Shingles Date: _____
RSV Date: _____

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