Initial History Questionnaire

Form Completed By:	Name:		
Date:	ID Number:		
Phone Number:	Birth Date:	Age:	Sex: M F

GENERAL

Do you consider your child to be in good health? □ Yes □ No □ Don't know Explain: _____

Does your child have any special health care needs? □ Yes □ No □ Don't know Explain: _____

Has your child ever been hospitalized? □ Yes □ No □ Don't know Explain: _____

Is your child allergic to medicine or drugs? □ Yes □ No □ Don't know Explain: _____

SOCIAL HISTORY

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? □ Yes □ No

If no, what is the child's current living situation?

□ Single-parent custody □ Joint custody □ Adoptive family

□ Other family members: _____ □ Foster care

How often does the child have visitation with parent(s) not living in the home?

BIRTH HISTORY

Birth weight: _____

□ Full-term □ Preterm _____ weeks □ Post-term _____ weeks

Delivery: □ Vaginal □ Cesarean □ Reason: _____

Any complications during birth or after birth? □ No □ Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

□ No □ Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins?	□ Yes	□ No	□ Unknown
Smoke or use e-cigarettes?	□ Yes	□ No	□ Unknown
Drink alcohol?	□ Yes	□ No	□ Unknown
Use marijuana?	□ Yes	□ No	□ Unknown
Use illicit drugs?	□ Yes	□ No	□ Unknown
Take other medications?	□ Yes	□ No	□ Unknown

If yes, please list:

Blood type:

Mother: _____ □ Unknown

Baby: _____ □ Unknown

Mother's lab results:

Hepatitis B	□ Pos	□ Neg	□ Unknown
HIV	□ Pos	□ Neg	□ Unknown
Group B streptococcus (GBS)	□ Pos	□ Neg	□ Unknown

After birth, did the baby get:

Vitamin K shot?	□ Yes	□ No	□ Unknown
Erythromycin eye ointment?	□ Yes	□ No	□ Unknown
Hepatitis B shot?	□ Yes	□ No	□ Unknown

How was the baby fed? □ Bottle formula □ Bottle breast milk

□ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? □ Yes

□ No Explain: _____

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY *(continued)*

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

Medications (Please list)

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

GLHS PATIENT REQUEST FOR RECORDS FROM OUTSIDE FACILITY

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

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

1. Information to be released FROM:

Facility or Physician Practice Name: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____

Fax Number: _____

2. Dates of Service to be Released: _____

3. Requestor: *(check one)* ☐ Self (Patient) OR ☐ Patient Representative (Name)_____

☐Parent/Guardian ☐HPOA ☐Executor of Estate ☐Other: _____

4. Release record copies TO:

☐ **Joint Township District Memorial**
Department **Attention To**: _____ **Fax**: _____
200 St. Clair Street
St. Marys, Ohio 45885

☐ **GL Family Practice & Pediatrics**
801 Pro Drive, Suite D1
Celina, Ohio 45822
Fax: 419-586-8509
P: 419-586-6489

☐ **GL Primary Care at St. Marys**
1140 S. Knoxville Ave, Suite A
St. Marys, Ohio 45885
Fax: 419-394-0255
P: 419-394-9959

☐ **GL Maria Stein Family Practice**
8381 State Route 119
Maria Stein, Ohio 45860
Fax: 419-925-4168
P: 419-925-4613

☐ **GL Miami & Erie Family Practice & Pediatrics**
4463 State Route 66, Suite A
Minster, Ohio 45865
Fax: 419-628-9501
P: 419-628-3821

☐ **GL Wapakoneta Primary Care**
812 Redskin Trail, Suite A
Wapakoneta, Ohio 45895
Fax: 419-738-4601
P: 419-738-4445

☐ **GL Pediatrics**
1010 Hager Street
St. Marys, Ohio 45885
Fax: 419-394-9580
P: 419-394-9579

☐ **GL Auglaize & Mercer General & Bariatric Surgery**
801 Pro Drive, Suite D2
Celina, Ohio 45822
Fax: 419-586-8574
P: 419-586-6480

☐ **GL Auglaize & Mercer General Surgery**
1140 S. Knoxville Drive, Suite C1
Celina, Ohio 45822
Fax: 419-394-9532
P: 419-394-9595

☐ **GL ENT and Sinus Center**
801 Pro Drive, Suite D4
Celina, Ohio 45822
Fax: 419-586-4125
P: 419-586-6480

☐ **GL Foot & Ankle Center**
1013 E. Spring Street
St. Marys, Ohio 45885
Fax: 419-394-1148
P: 419-394-8664

☐ **Kemmler Orthopaedic Center**
123 Hamilton Steet, Suite A
Celina, Ohio 45822
Fax: 419-568-7179
P: 419-586-5760

☐ **Grand Lake Neurology**
200 St. Clair Street, Suite 101
St. Marys, Ohio 45885
Fax: 419-394-9523
P: 419-394-9522

☐ **GL OB/GYN**
1140 S. Knoxville Ave, Suite B
St. Marys, Ohio 45885
Fax: 419-394-7313
P: 419-394-7314

☐ **GL Urology**
1140 S.Knoxville Ave, Ste. C2
St. Marys, Ohio 45885
Fax: 419-464-7083
P: 419-394-0326

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

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.
I understand that I may revoke this authorization at any time.

_____ _____

Signature of Patient or Patient Representative **Date**

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

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

GRAND LAKE
PHYSICIAN PRACTICES
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Authorization for Proxy Consent for Non-Urgent Pediatric Care

This form must be signed by the child's parent/guardian. By signing this form you authorize another adult to give consent for medical treatment of your child. Please read this form carefully.

This form is used to authorize an adult who is not the child's parent/guardian to consent to medical treatment for the child at _____ [*name of office/department*] ("Provider") in the absence of the parent/guardian and to allow Provider to release medical information about the child to the person providing proxy consent as necessary.

Name of Child: _____ Date of Birth: _____

☐ I **want** to be notified prior to any medical treatment such as injections or procedures. (Your child will Not receive treatment if you can't be reached/notified.)

☐ I give my proxy consent and do **not** want to be notified prior to any medical treatment such as injections or procedures.

This consent excludes immunizations. Parent or legal guardian must be present for vaccine administration.

Printed name of parent/guardian: _____

Statement of authorization by the parent/guardian: I hereby authorize the person(s) listed below to consent to medical treatment for my child, identified above, in my absence pursuant to Ohio Revised Code 2317.54(C)(2). I understand that as the parent/guardian I remain responsible for the costs of all treatment of my child even if consent is provided by a proxy. I understand that I may revoke this authorization at any time by providing written notice to: _____. In the event that the nature of the medical care requiring consent is not routine, the office may attempt to contact me but if unable to reach me you may rely on the proxy decision maker for consent. I understand that it may be necessary to disclose my child's protected health information to the person providing proxy consent and I hereby authorize Provider to disclose information for such treatment purposes.

Name of Adult Who May Give Consent in My Absence: _____
This Person's Relationship to Child: _____
This Person's Telephone Number: _____

Name of Adult Who May Give Consent in My Absence: _____
This Person's Relationship to Child: _____
This Person's Telephone Number: _____

GRAND LAKE PEDIATRICS
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Grand Lake Pediatrics
1010 Hager Street, St Marys, Ohio 45885
Phone: 419. 394. 9579 * Fax: 419. 394. 9580

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.