GRAND LAKE™
HEALTH SYSTEM

New Patient Packet Information:

We would like to take this opportunity to thank you for considering our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care, with a focus on wellness and prevention. Continuity and coordination of patient care is essential in meeting your healthcare needs. We work collaboratively with Joint Township District Memorial Hospital and a wide range of specialists to coordinate all aspects of patient care including inpatient hospitalization and specialty consultation care, as needed.

Prior to establishing with a new GLPP primary care physician, you may be asked to contact your previous physician and request that a copy of your medical records be sent to the new office.

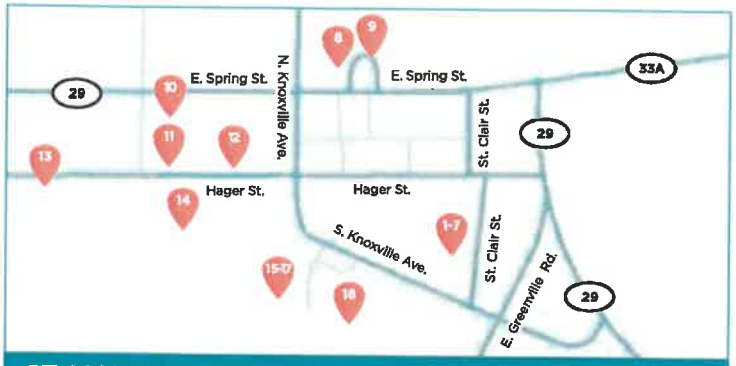
The enclosed forms will need to be completed and may need returned to the office prior to your appointment or brought with you to your appointment. You may also need to notify your health insurance company of your new primary care physician to ensure we are an in-network provider per your plan. You will need to bring your health insurance identification card, photo I.D. and any medications (actual pill bottles) you are currently taking with you to your visit.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

Grand Lake Health System

GRAND LAKE™ HEALTH SYSTEM



ST. MARYS

1 JOINT TOWNSHIP DISTRICT MEMORIAL HOSPITAL™
200 St. Clair Street
St. Marys, Ohio 45885-2400
Phone: 419.394.3335
Toll Free: 1.877.564.6897

2 GRAND LAKE OCCUPATIONAL MEDICINE™
200 St. Clair Street
St. Marys, Ohio 45885
Phone: 419.394.3335
- Juan Torres, MD
- Kimberly Wiener, APRN-CNP

3 URGENT CARE AT JTDMH
200 St. Clair Street
St. Marys, Ohio 45885-2400
Phone: 419.394.3335

4 GRAND LAKE NEUROLOGICAL CENTER™
200 St. Clair Street
St. Marys, Ohio 45885
Phone: 419.394.9522
- Natasha Alexander, DO
- Katherine Zwiebel, APRN-CNP

5 GRAND LAKE HEARTBURN CENTER
200 St. Clair Street
St. Marys, Ohio 45885
Phone: 419.300.1135

6 GRAND LAKE WOUND CARE CENTER™
200 St. Clair Street
St. Marys, Ohio 45885
Phone: 419.394.9512

7 CLEAR PASSAGE GERIATRIC PSYCHIATRIC CENTER
200 St. Clair Street
St. Marys, Ohio 45885
Phone: 419.394.9505

8 GRAND LAKE HOSPICE™
1122 East Spring Street
St. Marys, Ohio 45885
Phone: 419.394.7434
Toll Free: 1.800.543.5115
After Hours: 419.394.3335

9 GRAND LAKE HOME HEALTH™
1122 East Spring Street
St. Marys, Ohio 45885
Phone: 419.394.7434
Toll Free: 1.800.543.5115

10 GRAND LAKE FOOT AND ANKLE CENTER
1013 E. Spring Street
St. Marys, Ohio 45885
Phone: 419.394.8664
- Christopher J. Stucke, DPM

11 GRAND LAKE PEDIATRICS
Grand Lake Pediatrics Center
1010 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.9579
- Efren Aganon, MD
- Osagie Ighile, MD
- Thomas Zegarski, MD

12 GRAND LAKE PEDIATRIC REHAB
Grand Lake Pediatric Rehab
1040 Hager Street
St. Marys, Ohio 45885
Phone: 419.300.1140

13 GRAND LAKE SLEEP CENTER™
975 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.9992
- Jennifer Jacobs PA-C

14 GRAND LAKE REHAB AND WELLNESS CENTER
1065 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.9514

15 GRAND LAKE PRIMARY CARE AT ST. MARYS™
1140 S. Knoxville Ave., Suite A
St. Marys, Ohio 45885
Phone: 419.394.9959
- Padmaja Chalasani, MD
- Andrea Gonzalez, MD
- Michael Josey, MD
- Dawn McNaughton, MD
- Nicole Link, APRN-CNP
- Jayaben Patel, APRN-CNP

16 GRAND LAKE OB/GYN™
1140 S. Knoxville Ave., Suite B
St. Marys, Ohio 45885
Phone: 419.394.7314
- Polly Train, MD
- Whitney N. Clark, APRN-CNM
- Sara Gerlach, APRN-CNM
- Bridget Heckler, APRN-CNM
- Jackie Shriver, APRN-CNP

17 AUGLAIZE + MERCER GENERAL SURGERY
1140 S. Knoxville Ave., Suite C
St. Marys, Ohio 45885
Phone: 419.394.9595
- Lance Bryant, DO
- Ashley Meyer, APRN-CNP
- Brittany Schlarman, APRN-CNP

18 NEW DAY PAIN MANAGEMENT CENTER™
1165 S. Knoxville Ave., Suite 105
St. Marys, Ohio 45885
Phone: 419.394.9520
- John Buonocore, DO
- Amber Ball, APRN-CNP

CELINA

All are located in:
CELINA MEDICAL CENTER
801 Pro Drive
Celina, Ohio 45822

19 GRAND LAKE FAMILY PRACTICE & PEDIATRICS™
Phone: 419.586.6489
- Amy Branam, DO
- Luis Perez, DO
- Jessica Lozier, APRN-CNP

20 AUGLAIZE + MERCER GENERAL & BARIATRIC SURGERY
Phone: 419.586.6480
- James Reichert, DO
- Deanna Bruggeman, APRN-CNP
- Kevin Dirksen, APRN-CNP
- Lindsey Moeller, APRN-CNP

21 VANAN ENT & SINUS CENTER™
Phone: 419.586.6480
- Suri Vanan, MD
- Andrew Klausing, PA-C
- Heather Ott, APRN-CNP

22 GRAND LAKE OB/GYN™
Phone: 419.394.7314
- Polly Train, MD
- Sara Gerlach, APRN-CNM
- Bridget Heckler, APRN-CNM
- Jackie Shriver, APRN-CNP

23 GRAND LAKE PEDIATRICS
Phone: 419.394.9579
- Osagie Ighile, MD

24 KEMMLER ORTHOPAEDIC CENTER
123 Hamilton St.,
Celina, Ohio 45822
Phone 419.586.5760

140 Fox Road, Suite 209,
Van Wert, Ohio 45891
Phone 419.586.5760
- James Kemmler, MD
- Jed Kohne, PA-C

MOR Rehab
Phone 419.586.9300
Ciao! Med Spa
Phone 419.586.2426

25 GRAND LAKE FOOT AND ANKLE CENTER
123 Hamilton Street
Celina, OH 45822
Phone: 419.394.8664
- Christopher J. Stucke, DPM

COLDWATER

26 AUGLAIZE + MERCER GENERAL SURGERY
830 W. Main St, Ste. E1A
Coldwater, OH 45828
Phone: 419.394.9595
- Lance Bryant, DO
- Ashley Meyer, APRN-CNP
- Brittany Schlarman, APRN-CNP

26 AUGLAIZE + MERCER GENERAL & BARIATRIC SURGERY
830 W. Main St, Ste. E1A
Coldwater, OH 45828
Phone: 419.586.6480
- James Reichert, DO
- Deanna Bruggeman, APRN-CNP
- Kevin Dirksen, APRN-CNP
- Lindsey Moeller, APRN-CNP

MINSTER

27 MIAMI & ERIE FAMILY PRACTICE & PEDIATRICS
04463 State Route 66
Minster, Ohio 45865
Phone: 419.628.3821
- Olubukola Adeloia, MD
- James Luedeke, MD
- Sarah Werner, DO
- Sara Hess, APRN-CNP

WAPAKONETA

All located in:
WAPAKONETA MEDICAL CENTER
812 Redskin Trail
Wapakoneta, OH 45895

WAPAKONETA PRIMARY CARE™
Phone: 419.738.4445
- V.K. Chalasani, MD

VANAN ENT & SINUS CENTER
Phone: 419.586.6480
- Suri Vanan, MD
- Andrew Klausing, PA-C
- Heather Ott, APRN-CNP

GRAND LAKE PEDIATRICS
Phone: 419.394.9579
- Thomas Zegarski, MD

33122 - 011823

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
- ☐ Eggs
- ☐ Grains/Wheat
- ☐ Nuts/Peanuts
- ☐ Shellfish
- ☐ Strawberries
- ☐ Tylenol
- ☐ Aspirin
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ NSAIDS
- ☐ Penicillin
- ☐ Adhesive Tape
- ☐ Cosmetics
- ☐ Detergent
- ☐ Latex
- ☐ Metals
- ☐ Molds/Mildew
- ☐ Animal Dander
- ☐ Dust
- ☐ Grass
- ☐ Insect bites/Stings
- ☐ Mites
- ☐ 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
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Migraines
- ☐ Cancer type _____
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Thyroid Disorder

Other medical problems: _____

_____

FAMILY MEDICAL HISTORY – please indicate who has this in your family (Mother, Father, Brother, Sister, Paternal Grandparent, Maternal Grandparent, Children)

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

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
   - ☐ History & Physical
   - ☐ Consultation
   - ☐ Operative Report
   - ☐ Discharge Instruction Sheet
   - ☐ ER Chart
   - ☐ Urgent Care Chart
   - ☐ Laboratory Reports
   - ☐ Medical Imaging Reports
   - ☐ EKG
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ All Dictated Reports
   - ☐ Other (specify): _____

   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.:

$ 19.58 record search fee.
$ 1.29 per page for first ten pages.
$ .66 per page for pages eleven through fifty.
$ .27 per page for pages fifty-one and higher.

Medical Images

$ 2.18 per page