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 focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioners, nurses, medical assistants and office staff work closely in a “team approach” to support your patient care. 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. If required, you will also need to notify your health insurance company of your new primary care provider. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. Please bring your health insurance identification card, photo I.D., and any medications (actual pill bottles) you are currently taking.

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
## PATIENT INFORMATION

- **HOW DID YOU HEAR ABOUT US?**
- **SOCIAL SECURITY #**
- **FIRST NAME**
- **MIDDLE**
- **LAST NAME**
- **SEX**
- **DATE OF BIRTH**
- **RACE**
- **PREFERRED LANG.**
- **OTHER**
- **ETHNICITY**
- **MARITAL STATUS**
- **MARRIED**
- **SINGLE**
- **DIVORCED**
- **WIDOWED**
- **LEGAL 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**
- **FATHER’S NAME**
- **ADDRESS**
- **SSN**
- **DOB**
- **EMPLOYER**
- **WORK PHONE**

## INSURANCE INFORMATION

Please provide your insurance card to the receptionist.

- **Medicaid**
- **Medicare**
- **None**
- **Other**
- **INSURER’S NAME**
- **REINSURANCE**
- **DATE OF BIRTH**
- **SSN**
- **CO-PAY**
- **POLICY NUMBER**

## SECONDARY INSURANCE INFORMATION

- **Medicaid**
- **Medicare**
- **None**
- **Other**
- **INSURER’S NAME**
- **REINSURANCE**
- **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 UNLESS 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**

PP-001pc
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
☐ Sulfas Drugs
☐ NSAIDS
☐ Penicillin
☐ Adhesive Tape
☐ Cosmetics
☐ Detergent
☐ Latex
☐ Metals
☐ Molds/Mildew
☐ Animal Dander
☐ Dust
☐ Grass
☐ Insect bites/Stings
☐ Mites
☐ Pollen

Please list any other allergies you may have: ___________________________

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 ___________________________
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.

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<th>MEDICATION</th>
<th>DOSAGE</th>
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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)__________________________