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

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

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

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

7 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

8 GRAND LAKE PRIMARY CARE AT ST. MARYS™
1040 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.9959
- Michael Josey, MD
- Dawn McNaughton, MD
- Nicole Link, APRN-CNP
- Ashley Meyer, APRN-CNP

9 GRAND LAKE PEDIATRICS
Grand Lake Pediatrics Center
1010 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.9579
- Efren Aganon, MD
- Thomas Zegarski, MD
- Julie DeVine, APRN-CNP
- Julie Westgerdes, APRN-CNP

10 GRAND LAKE OB/GYN™
1067 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.7314
- Polly Train, MD
- Sara Gerlach, APRN-CNP
- Bridget Heckler, APRN-CNM
- Jackie Shriver, APRN-CNP
- Marianne Voigt, APRN-CNM

11 GRAND LAKE SLEEP CENTER™
975 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.9992
- Sarat Kuchipudi, MD

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

13 GRAND LAKE REHAB SERVICES™ (OUTPATIENT)
1065 Hager Street
St. Marys, Ohio 45885
Phone: 419.394.9514

14 AUGLAIZE + MERCER GENERAL & BARIATRIC SURGERY
1300 E. Greenville Rd., Ste. B,
St. Marys, Ohio 45885
Phone: 419.394.9595
- Lance Bryant, DO
- Brittany Schlarman, APRN-CNP

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

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

CELINA

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

17 GRAND LAKE FAMILY PRACTICE & PEDIATRICS™
Phone: 419.586.6489
- Luis Perez, DO
- Jessica Lozier, APRN

18 AUGLAIZE + MERCER GENERAL & BARIATRIC SURGERY
Phone: 419.586.6480
- James Reichert, DO

19 VANAN ENT & SINUS CENTER™
Phone: 419.586.6480
- Suri Vanan, MD
- Christy Kretzer, APRN-CNP
- Andrew Klausing, PA-C

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

21 GRAND LAKE PEDIATRICS
Phone: 419.394.9579
- Julie Westgerdes, APRN-CNP

22 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

23 GRAND LAKE FOOT AND ANKLE CENTER
123 Hamilton Street
Celina, OH 45822
Phone: 567.890.2655
- Christopher J. Stucke, DPM

AUGLAIZE + MERCER UROLOGY
950 S. Main St. Ste 10
Celina, Ohio 45822
Phone 419.586.6899
- Scott Cohen, MD

MINSTER

24 GRAND LAKE PEDIATRICS
4 Eagle Drive
Minster, Ohio 45865
Phone: 419.394.9579
- Efren Aganon, MD
- Julie DeVine, APRN-CNP

24 GRAND LAKE OB/GYN™
4 Eagle Drive
Minster, Ohio 45865
Phone: 419.394.7314
- Polly Train, MD
- Sara Gerlach, APRN-CNP
- Bridget Heckler, APRN-CNM
- Jackie Shriver, APRN-CNP
- Marianne Voigt, APRN-CNM

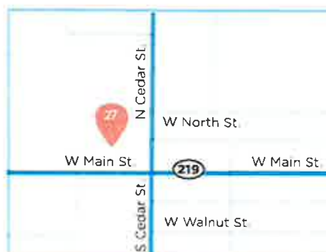
25 MIAMI & ERIE FAMILY PRACTICE & PEDIATRICS
04463 State Route 66
Minster, Ohio 45865
Phone: 419.628.3821
- Olubukola Adelola, MD
- James Luedeke, MD
- Sarah Werner, DO
- Sara Hess, APRN-CNP

WAPAKONETA

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

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

GRAND LAKE PEDIATRICS
Phone: 419.394.9579
- Thomas Zegarski, MD



COLDWATER

27 AUGLAIZE + MERCER GENERAL & BARIATRIC SURGERY
800 W. Main St., 2nd Floor Clinic, 2E, Coldwater, OH 45828
Phone: 419.394.9595
- Lance Bryant, DO
- Brittany Schlarman, APRN-CNP

33122 - 030920

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 ____________

RELATIONSHIP

HOME PHONE ____________

WORK PHONE ____________

IF MARRIED, SPOUSE INFORMATION

NAME ____________

EMPLOYER ____________

DATE OF BIRTH ___/___/_____ SSN ____________

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

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

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.

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*)

____
____
____
____
____
____