OMH Oncology/Infusion Center
701 N. Otsego Ave.
Gaylord, MI 49735
Phone (989) 731-7760
Fax (989) 731-7748

Today's date ______________________

Patient Name: ____

Date of Birth: ______________________________

Dear New Patient:

It is a pleasure to welcome you as a new patient to our office. You will find we are dedicated to quality and excellence in our patient care. Your appointment is scheduled as follows:

____

In order to expedite our check-in process, please complete the enclosed patient history forms prior to your appointment. When you arrive at our office on your appointment day:

- Arrive 30 minutes early (unless otherwise advised)
- Bring completed paperwork from this packet.
- Bring all insurance cards, prescription medication/pharmacy cards, advance directive forms, legal guardianship documents, or durable power of attorney for financial/medical care documents, and photo identification.
- Bring ALL of your medications (in the original bottles), including your non-prescription & over-the-counter medications (aspirin, vitamins, supplements, etc.)

Due to the specialized nature of our practice, if you arrive more than ten minutes late or do not have the necessary paperwork, you will need to reschedule your appointment.

We appreciate the trust and confidence you have placed in our practice and the unique care we provide. We look forward to meeting you soon.

Sincerely,

Jennifer Lawhorn D.O.
Lori Schiller, Nurse Practitioner
And the Oncology Staff

Our office hours are 8:00 am – 5:00 pm Monday through Friday

OMH Otsego Memorial MEDICAL GROUP

Health History Today's Date:___________________

Please answer the questions below. This information will be kept confidential and used for your continuing care.

Name: ____ DOB: __________________ Handedness:

Primary Care Physician: _________________________________ Right _______

Referring Physician: ____________________________________ Left _______

Date of Last Physical Exam: _____________________________ Height: _______ Weight: _______

Date of Last Eye Exam/Doctor: ___________________________ Last Dental Exam/Dentist: _________________________

Preferred Pharmacy: ____

Personal History

Please check and ***list date or age*** if you have ever had any of the problems listed below.

Problem	*Date/Age*	*Problem*	*Date/Age*	*Problem*	*Date/Age*
__ A-Fib/Atrial Fibrillation	______	__ Dementia	______	__ Pacemaker	______
__ Aids or HIV+	______	__ Emphysema __ COPD	______	__ Phlebitis	______
__ Alcoholism	______	__ Eye Disease	______	__ Defibrillator	______
__ Alzheimer's	______	__ GERD/Gastro Refluxe	______	__ Deep Vein Thrombosis	______
__ Anemia	______	__ Gall Bladder Disease	______	__ Pleurisy	______
__ Aneurysm/ location:	______	__ Glaucoma	______	__ Polio	______
__ Anorexia __ Bulimia	______	__ Goiter	______	__ Prostate Problems	______
__ Arthritis/Rheumatism	______	__ Gout	______	__ Psoriasis	______
__ Asthma	______	__ Heart Attack	______	__ Psychiatric Care	______
__ Back Trouble	______	__ Heart Disease	______	__ Rheumatic Fever	______
__ Bladder Infections	______	__ Heart Valve Problem	______	__ Sciatica	______
__ Broken Bones/Recurrent Dislocations	______	__ Hepatitis/Jaundice	______	__ Sexually Transmitted Disease	______
		__ Hemorrhoids	______		
__ Bronchitis/Pneumonia	______	__ Hernia	______	__ Sleep Apnea	______
__ Blood or Plasma Transfusions	______	__ Herpes	______	__ Stomach Trouble	______
__ Bursitis	______	__ High/Low Blood Pressure	______	__ Strep Throat	______
__ Cancer/*Type* ________	______	__ High Cholesterol	______	__ Stroke	______
__ Cataracts	______	__ Hypoglycemia	______	__ Thyroid Problems	______
__ Chemical Dependency	______	__ Kidney Disease	______	__ Tonsillitis	______
__ Chicken Pox	______	__ Liver Disease	______	__ Tuberculosis	______
__ Colitis/Bowel Problems	______	__ Measles	______	__ Positive TB Test	______
__ Concussions/Head Injury	______	__ Meningitis	______	__ Ulcers	______
__ Convulsions/Seizures	______	__ Migraine Headaches	______	__ Varicose Veins	______
__ Diabetes	______	__ Mumps	______	__ Whooping Cough	______
__ Depression/Mental Illness	______	__ Obesity	______	__ Other ____________	______

Social History

How often do you:

Exercise __________________ *Drink:* Alcohol __________ Caffeine __________

Use Tobacco: Cigarettes ____packs per day for ___ years Cigars ___ per day for ___ years

Chew ___ Snuff ___ Exposed to secondhand smoke ___ yes ___ no

Use Marijuana: _____yes _____no If yes, are you Medical Marijuana card holder: _____yes _____no

Use street drugs: ___________

Your occupation: ________________________ Marital status: _______________ Children________________

Reviewed by: ________________________________ **on** ____________________

Provider Date

Name: ____________________________________ DOB: _______________

Surgery

Have you had removed:

Have you had problems with anesthesia? ____ *Yes* _____ *No*

__ Tonsils __ Adenoids __ Tubes in Ears/***Date*** **:** ____ __ Hernia Repair __ Gall Bladder

__ Vasectomy __ Appendix __ Colonoscopy/***Date***:______ __ EGD/***Date***:________ __ Hemorrhoids

__ C-Section __ Tubal Ligation __ Fallopian Tubes __ Ovaries __ Uterus

Orthopedic Procedures (bone/joint)

__ Arthroscopy (what joint(s)): _____________________________ __ Joint Replacement

__ Other____ *Type/When*: _________________________________

__ Other____ *Type/When*: _________________________________

Cardiovascular Procedures (heart/blood vessels)

__ Catheterization __ Open heart surgery __ Valve Replacement

__ Stents/type (please have stent card available) __ Vascular Graft (for example, bypass surgery)

__Renal __Cardiac __Vascular *Type/When*: _________________________________

Other Operations____

Family History: Please fill in the health information about your immediate family

	Age/Health Status	List any Health Conditions	If Deceased	
			Cause of Death	**Date**
Father				
Mother				
Brother				
Sister				

Have you recently had any of the following:

__ Abdominal pain

__ Weight Loss

__ Change in bowel habits

__ Change in stool size

__ Blood in stool

__ Family history of colon cancer or polyps

__ Exposure to pets

__ Valve disease requiring antibiotics

__ Blood thinner

Women:

__ Abnormal Pap Smear

__ Breast lump, pain, or discharge

__ Menstrual pain or cramps

Age Periods Began ___________

No. of Days Flow ___________

Date of last menstrual period ___________

Date of last Pap Smear ___________

Date of last Mammogram ___________

Where? ____________________

__ Menopause/***Date*** _______

No. of Pregancies ______

No. of Deliveries ______

No. of Miscarriages ______

No. of Abortions ______

Men:

__ Breast lump

__ Breast lump, pain, or discharge

__ Erection difficulties

__ Testicle pain or swelling

__ Sore on penis or discharge

__ Problem with urination

Allergies: Include food, drug, and environmental allergies

Allergies:	Reaction:	Are you allergic to **Latex?** _____ *Yes* _____ *No*
		Are you allergic to **Iodine - CT dye - MRI dye**? _____ *Yes* _____ *No*
		Are you allergic to or have sensitivities to **Metals?** _____ *Yes* _____ *No*

Reviewed by: ____ **on** _________________________

Provider Date

Name: ___________________________________ DOB: _______________ Today's Date: ________________

Medications: Please list all medications you are currently taking including all over-the-counter and vitamins and/or supplements.

Medication Name	Strength	How many/How often?	Reason for taking

Please check if you have recently experienced any of the following:

Systemic Symptoms
__ Weight Change
__ Chills
__ Fever
__ Feeling tired or poorly
__ Other
__ Hot flashes

Head Symptoms
__ Headache
__ Facial Pain __ Sinus Pain
__ Other Head-related Symptoms

Eye Symptoms
__ Eyesight Problems
__ Photophobia
__ Eye pain
__ Itching of the eyes
__ Other Eye Symptoms

Ears/Nose/Throat
__ Earache
__ Hearing Loss
__ Ringing in the Ears
__ Nosebleeds
__ Nasal Discharge
__ Mouth Sores
__ Bleeding Gums
__ Hoarseness
__ Throat Pain
__ Other Symptoms

__ Other (Please specify below):

____

____

____

Neck Symptoms
__ Neck Pain
__ Neck Stiffness
__ Lump or Swelling in Neck
__ Other Neck Systems

Cardiovascular
__ Chest pain or discomfort
__ Fast Heart Rate
__ Palpitations
__ Other Cardiovascular Symptoms

Pulmonary Symptoms
__ Shortness of Breath
__ Cough
__ Coughing up blood
__ Night Sweats
__ Wheezing
__ Other Pulmonary Symptoms

Gastrointestinal Symptoms
__ Appetite Problems
__ Difficulty Swallowing
__ Heartburn
__ Nausea
__ Vomiting
__ Abdominal Pain
__ Diarrhea
__ Black or Bloody Stools
__ Other Gastrointestinal Symptoms
__ Constipation

Genital or Urinary
__ Painful or difficult urination
__ Increased Frequency
__ Bloody urine
__ Genital Lesions
__ Other Genital or Urinary Symptoms

Skin Symptoms
__ Itching
__ Lesion/sores
__ Rashes
__ Other Skin Symptoms

Endocrine Symptoms
__ Excess Sweating
__ Excessive Thirst
__ Libido has changed

Musculoskeletal System
__ Joint Pain, localized
__ Joint Stiffness, localized
__ Muscle aches
__ Other Musculoskeletal Symptoms

Neurological Symptoms
__ Dizziness
__ Vertigo
__ Fainting
__ Difficulty Moving/walking
__ Changes in sensation
__ Numbness/tingling

Psychological Symptoms
__ Sleep Disturbances
__ Anxiety
__ Depression
__ Other Psychological Symptoms

Reviewed by: ______________________________________ **on** ________________________
Provider Date

Completed on: ____________	Pt Acct # ________________	☐ Given to patient
Completed by: ___________ (Initials)	MR# ________________	☐ Mailed to patient/other

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AUTHORIZATION FOR RELEASE OF INFORMATION

(Request by Patient or Patient's Representative)

I hereby authorize ____ (Name of Health Care Provider) to disclose my individually identifiable health information as described below, including but not limited to information concerning communicable diseases such as venereal disease, TB, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency, psychological or psychiatric records, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations.

____

Print Patient Name Date of Birth

____

Address City State Zip Code

Date of service (if known): ____

Description of information to be released (check all that apply):

____ Emergency Room/MedCare Clinic ____ Admission records (H&P) ____ Progress notes ____ Discharge Summary
____ Consultation reports ____ Physician orders ____ Operative records ____ X-ray reports
____ Nurses' notes ____ Laboratory reports ____ X-ray films ____ Billing records
____ Other (specify) ____

Description of the purpose of the use and/or disclosure (see examples): ______________________

The health information described herein shall be released to: __Hospital __Physician __Insurance Company __Attorney ____Patient (self) __Other __________________________ (check appropriate category)

____

Name or Organization Address City State ZIP

I understand that this authorization will expire in 60 days from the date signature.

I further understand that I may revoke this authorization at any time by notifying Physician Services Administration, Otsego Memorial Hospital in writing.
I also understand that the written revocation must be dated with a date that is later than the date on this authorization and signed. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that my continued or future treatment by or payment to Otsego Memorial Hospital is not conditioned upon my providing or signing this authorization. I understand that I have the right to inspect or copy the health information Otsego Memorial Hospital intends to use or disclose pursuant to this authorization, and I may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.

__________(initials) I have been provided with a copy of this authorization for my records.

________________________________ ________________________

Signature of Patient or Patient's Representative **Date**

________________________________ ________________________

Printed Name of patient's Representative **Signature of witness**

________________________________ ________________________

Relationship to Patient OR Legal Authority (attach supporting documentation)

PATIENT PRIVACY

AND

PHONE MESSAGES

Patient Name: ______________________________________ **Date of Birth**______________________

(Please Print)

PEDIATRIC PATIENTS ONLY:

Mother (or Legal Designee): ____

(Please Print)

Father (or Legal Designee): ____

(Please Print)

How our office should reach you:

	Type:	May we leave a message or voice mail?
Primary ( )	Home Mobile Work	**Circle:** Yes or No
Other ( )	Home Mobile Work	**Circle:** Yes or No
Other ( )	Home Mobile Work	**Circle:** Yes or No
Other ( )	Home Mobile Work	**Circle:** Yes or No

SHARE: (List the full name of the family members and/or friends who are or may be involved with your care that Otsego Memorial Hospital may share your health information with)

DO NOT SHARE MY HEALTH INFORMATION WITH THE FOLLOWING: (List the full name)

My signature below indicates I have completed the above sections to the best of my ability. I understand that I may change the responses provided at any time by making a change in writing.

______________________________________ ______________________

Signature of Patient, Parent, or Legal Guardian Date

______________________________________ ______________________

Printed Name of Parent or Legal Guardian Date

Rev 1/16/18

Consent To The Use And Disclosure Of Health Information For Treatment, Payment And Healthcare Operations

I understand that as part of my healthcare, Otsego Memorial Hospital uses health information and medical records describing all aspects of my care. It is used for:

- Planning my care and treatment
- Communicating with health professionals involved in my care
- A source of information for billing
- A means by which any payer can verify that services billed were provided, and assist with our providers being paid for services and care provided to me; and
- A tool used for routine healthcare operations to measure the quality of my care

- I acknowledge that (1) if I am a first time patient, I was offered and have received a copy of Otsego Memorial Hospital's Notice of Privacy Practices; or (2) if I am not a new patient to Otsego Memorial Hospital, I have received a Notice of Privacy Practices at a previous visit.
- I understand that Otsego Memorial Hospital reserves **the right to change this notice** and will post a copy of any revised Notice in its waiting rooms and examination rooms and will provide me with a copy upon my request.
- I understand that **I have the right to object** to the use of my health information for directory purposes and to request restrictions as to how my health information is used or shared to carry out treatment, payment, or healthcare operations.
- I understand that **Otsego Memorial Hospital is not required to agree** to the restrictions requested.
- I understand that **I may cancel this Consent in writing**, except to the extent that Otsego Memorial Hospital has already used the information while the consent was active.

- The Notice of Privacy Practices is posted in a clear and prominent location where I am able to read the Notice
- I know that I can ask for a copy of the Notice of Privacy Practices to take with me
- I was able to view the Notice of Privacy Practices on the first day I received health care services
- I am able to view the Notice electronically at the OMH website and OMH Patient Portal
- If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practicable after the emergency treatment

____ ____________________

Signature of Patient, Parent, or Legal Guardian | Date