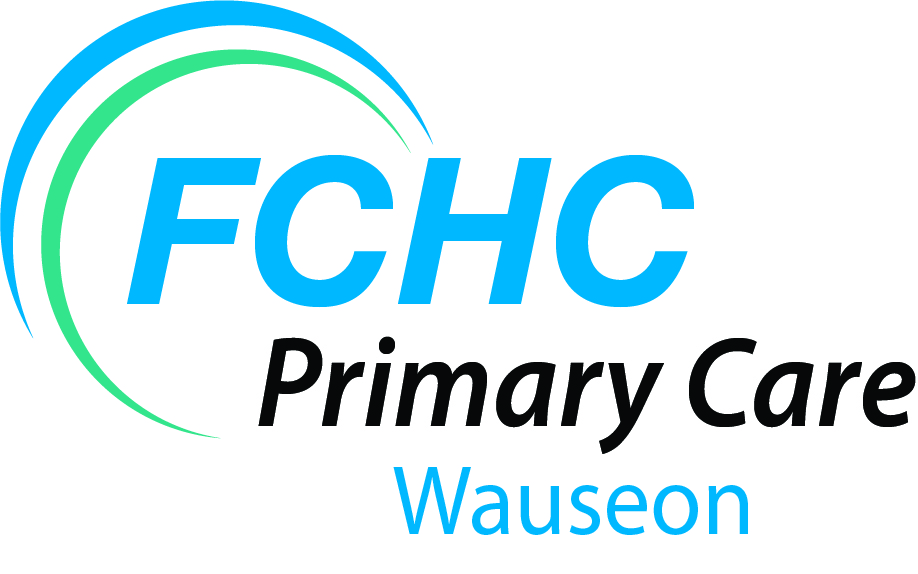
Welcome to

****

**Welcome!**

Thank you for choosing us to be part of your healthcare team. We look forward to working with you to make sure you receive the care you need and keep you healthy and happy. We hope that the information provided on this guide will answer many of the questions you may have about our practice.

**Appointments**

If you have an emergency illness or symptom that requires immediate, urgent attention, call 911. If you need an appointment for illness, symptom, check-up, follow-up visit or annual visit call the office.

Please arrive 15 minutes prior to your appointment time. Patients who are more than 10 minutes late may be required to reschedule their appointments. Patients with 3 no-show appointments may result in dismissal from practice. Patients under the age of 18 must be accompanied by a parent or legal guardian at all appointments unless authorization for another adult to bring minor patient has been completed.

**Appointment Check List**

* Your insurance card.
* Current prescription bottles and non-prescription medications, vitamins and supplements bottles.
* A good description of the problem, how long you have had it and how it affects you.
* A list of questions you would like to discuss with your provider.
* A list of other health care providers you have visited.

**Payment Options**

We participate in most insurance plans, including Medicare. Be sure to check with your insurance to see if we are an in network provider. Please note that it is your responsibility to ensure that we are a covered provider.

Please be prepared to pay your co-pay and/or patient balance at the time of service. We accept cash, checks, Visa, MasterCard and Discover credit cards.

We are happy to answer questions, discuss payments or your bill anytime by calling (419) 330-1550.

**Prescriptions**

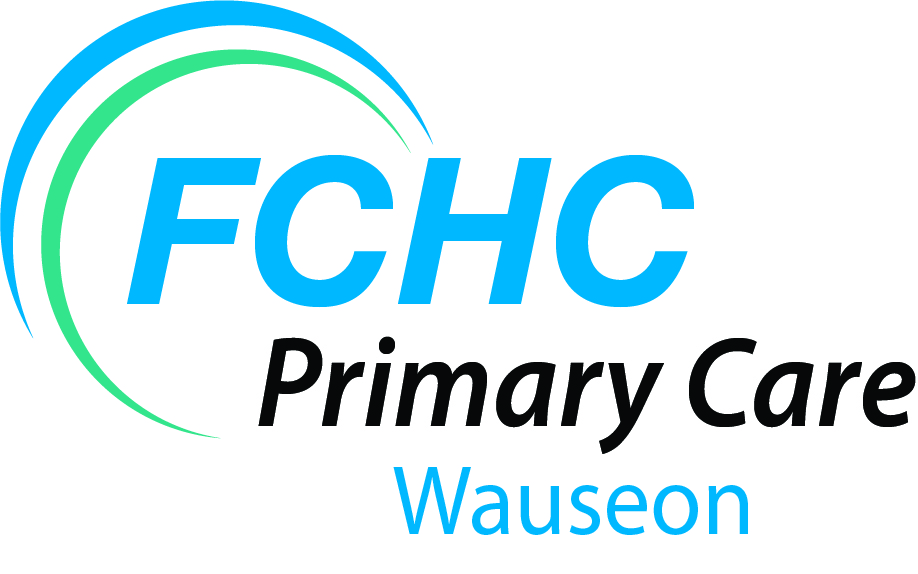
For refills of prescriptions, please contact your pharmacy. Please allow 48 hours for us to refill your prescriptions. We will contact you only if there is a problem or we have a question about your prescription refill request.

Please remember that refills can only be given to patients who have been seen within the past six months. If you have not been seen for more than six months, you will need to schedule an appointment.

If you have questions about a new prescription or about discontinuing medication(s), please call and speak with your provider’s nurse.

**After-Hours Care**

If you would like to speak to the clinician on call to help you decide how to treat an illness after hours or to help you decide whether to go to the emergency room, call the On Call Service. If you receive care at an emergency room or urgent care center, please let us know by calling the office within 48 hours so we can assist with follow-up care as needed.

****

**Providers**Richard L. Grieser, MD   
Rebecca L. McClarren, MD  
Leslie S. Clemensen, MD  
Marissa M. Baus, NP  
Jacob J. Grime, CNP  
Taylor L. Short, CNP

**Address**735 S Shoop Ave  
Wauseon, OH 43567

**Office Phone**(419) 335-3242

Use this number to schedule appointments, answer your general questions and connect you with team members.

**Office Fax**(419) 335-3222

**Office Hours**Monday-Thursday 8:00 am – 4:30 pm  
Friday  
8:00 am – 4:00 pm

**On Call Service Phone** (844) 694-1264

Use this number after hours and on weekends to talk to the On Call provider when the office is closed.

**Website**

fchcprimarycarewauseon.org

**Patient Registration Form**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Sex ❑ Male ❑ Female SS#\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy/City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May Leave Message ❑ Yes ❑ No

Appointment Reminders – Check One ❑ Call Home Phone ❑ Call Cell Phone ❑ Text Cell Phone

Primary Language ❑ English ❑ Spanish ❑ ASL ❑ Other \_\_\_\_\_ Interpreter Needed ❑ Yes ❑ No Marital Status\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Race: | ❑ American Indian/Alaska Native | ❑ Asian | ❑ Black/African American | |
| ❑ Native Hawaiian/Other Pacific Islander | ❑ White | ❑ Other | ❑ Unknown |
| Ethnicity: | ❑ Hispanic/Latino | ❑ Not Hispanic/Latino | | ❑ Unknown |

Fulton County Health Center is asking you to complete the next section to meet the requirements of Section 1557 of the Affordable Care Act. This is not specific to Fulton County Health Center, all healthcare facilities must comply.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Sexual Orientation: | ❑ Straight | ❑ Bisexual | ❑ Lesbian/Gay/Homosexual | | ❑ Don’t Know | ❑ Declined |
| Gender Identity: | ❑ Female | ❑ Male | ❑ Trans Male  (female to male) | ❑ Trans Female  (male to female) | ❑ Don’t Know | ❑ Declined |

**Guarantor – Person Financially Responsible**

❑ Same as Patient Information

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Home ❑ Cell Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

❑ Self-Pay

**Primary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Same as Patient Information (If the patient is NOT the Subscriber please provide additional information)

Subscriber Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Subscriber Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Same as Patient Information (If the patient is NOT the Subscriber please provide additional information)

Subscriber Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Subscriber Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that the above information is correct to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Authorized Representative Signature Date

**Communication Release Form**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Fulton County Health Center strives to keep your Protected Health Information (PHI) and personal information secure. Requests, usage and disclosure of information is only granted to meet the intended need. You may change your Authorized Representatives at any time.   
  
❑ **DO NOT DISCLOSE** any information to anyone but me.

**Authorized Representatives**

I give permission for the following people to receive information as specified. Please mark all that apply.

***Primary Contact***

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ­­­(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

***Secondary Contact***

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ­­­(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

***Additional Contact***

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ­­­(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

***Additional Contact***

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ­­­(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Representative Signature Date

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **FCHC - PATIENT HEALTH HISTORY FORM**  **PLEASE COMPLETE IN BLACK INK** | | | | | | | | | | | | | | | | | | | | | | | | TODAY’S DATE PAGE 1 | | | | | | | | | | |
| LAST NAME | | | | | | | | | | LEGAL FIRST NAME | | | | | | | | | | | | | | MI | | | | | | DATE OF BIRTH | | | | |
| **YOUR HEALTH HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Check all items either**  **No or Yes** | **No** | | | **Yes, Now** | | | **Yes, Past** | | | **Check all items either**  **No or Yes** | | | | | | | | | | **No** | **Yes, Now** | **Yes, Past** | | **Check all items either**  **No or Yes** | | | | | | | **No** | | **Yes, Now** | **Yes, Past** |
| **CARDIOVASCULAR** | | | | | | | | | | **EYES** | | | | | | | | | | | | | | **INTEGUMENTARY/SKIN** | | | | | | | | | | |
| Drug Allergies |  | | |  | | |  | | | Blurred Vision | | | | | | | | | |  |  |  | | Boils/Lesions | | | | | | |  | |  |  |
| Hay Fever |  | | |  | | |  | | | Double Vision | | | | | | | | | |  |  |  | | Persistent Itch | | | | | | |  | |  |  |
| Latex Allergy |  | | |  | | |  | | | Eye Pain | | | | | | | | | |  |  |  | | Skin Rash | | | | | | |  | |  |  |
| High Blood Pressure |  | | |  | | |  | | | Failing Vision | | | | | | | | | |  |  |  | | **MUSCULOSKELETAL** | | | | | | | | | | |
| Low Blood Pressure |  | | |  | | |  | | | Vision Loss | | | | | | | | | |  |  |  | | Back Pain | | | | | | |  | |  |  |
| Palpitations |  | | |  | | |  | | | **GASTROINTESTINAL** | | | | | | | | | | | | | | History of Falls | | | | | | |  | |  |  |
| Varicose Veins |  | | |  | | |  | | | Abdominal Pain | | | | | | | | | |  |  |  | | History of Fractures | | | | | | |  | |  |  |
| **CONSTITUTIONAL** | | | | | | | | | | Appetite Loss | | | | | | | | | |  |  |  | | Joint Pain | | | | | | |  | |  |  |
| Chills |  | | |  | | |  | | | Blood in Stool | | | | | | | | | |  |  |  | | Neck Pain | | | | | | |  | |  |  |
| Fatigue or Weakness |  | | |  | | |  | | | Constipation | | | | | | | | | |  |  |  | | **NEUROLOGICAL** | | | | | | | | | | |
| Fever |  | | |  | | |  | | | Diarrhea | | | | | | | | | |  |  |  | | Dizzy Spells | | | | | | |  | |  |  |
| Headache (Frequent) |  | | |  | | |  | | | GI Bleed | | | | | | | | | |  |  |  | | Memory Loss | | | | | | |  | |  |  |
| Weight Gain |  | | |  | | |  | | | Indigestion/Heartburn | | | | | | | | | |  |  |  | | Numbness/Tingling | | | | | | |  | |  |  |
| Weight Loss |  | | |  | | |  | | | Nausea/Vomiting | | | | | | | | | |  |  |  | | Seizures | | | | | | |  | |  |  |
| **EAR/NOSE/THROAT** | | | | | | | | | | Ulcers/Reflux/GERD | | | | | | | | | |  |  |  | | Stroke | | | | | | |  | |  |  |
| Difficulty Hearing |  | | |  | | |  | | | **GENITOURINARY** | | | | | | | | | | | | | | Tremors | | | | | | |  | |  |  |
| Ear Infections |  | | |  | | |  | | | Bladder Leakage | | | | | | | | | |  |  |  | | **PSYCHIATRIC** | | | | | | | | | | |
| Ringing Ears |  | | |  | | |  | | | Blood in Urine | | | | | | | | | |  |  |  | | Anxiety | | | | | | |  | |  |  |
| Sinus Trouble |  | | |  | | |  | | | Painful Urination | | | | | | | | | |  |  |  | | Depression | | | | | | |  | |  |  |
| Sore Throat |  | | |  | | |  | | | Urinary Frequency | | | | | | | | | |  |  |  | | Difficulty Sleeping | | | | | | |  | |  |  |
| **ENDOCRINE** | | | | | | | | | | Urine Retention | | | | | | | | | |  |  |  | | **RESPIRATORY** | | | | | | | | | | |
| Cold Intolerance |  | | |  | | |  | | | **HEMATOLOGIC/LYMPHATIC** | | | | | | | | | | | | | | Difficulty Breathing | | | | | | |  | |  |  |
| Excessive Thirst |  | | |  | | |  | | | Abnormal Bleeding | | | | | | | | | |  |  |  | | Frequent Cough | | | | | | |  | |  |  |
| Heat Intolerance |  | | |  | | |  | | | Bleeding Disorders | | | | | | | | | |  |  |  | | History/Exposure TB | | | | | | |  | |  |  |
| Thyroid Trouble |  | | |  | | |  | | | Blood Clotting Problems | | | | | | | | | |  |  |  | | Shortness of Breath | | | | | | |  | |  |  |
| Tired/Sluggish |  | | |  | | |  | | | Swollen Glands | | | | | | | | | |  |  |  | | Wheezing | | | | | | |  | |  |  |
| **HABITS/SOCIAL HISTORY** | | | | | | | | | | | | | | | | | | | **MEDICATIONS** | | | | | | | | | | | | | | | |
| **Do you:** | | **No** | | | | **Yes** | | | | **If Yes, how much?** | | | | | | | | | Please list all medications you are now taking, including those you buy without a doctor’s prescription (over-the-counter, supplements, herbals, etc.) | | | | | | | | | | | | | | | |
| Smoke Tobacco | |  | | | |  | | | | Packs/Day | | | | | | | | |
| Chew Tobacco | |  | | | |  | | | | Tins or Bags/Day | | | | | | | | |
| **Did you Smoke?** | |  | | | |  | | | | Year Quit | | | | | | | | | **What pharmacy do you use?** | | | | | | | | | |  | | | | | |
| How many years did you smoke? | | | | | | | | | | Packs/Day | | | | | | | | | **Medication** | | | | | | | **Dosage** | | | **How many times a day?** | | | | | |
| Drink Alcohol or Wine | |  | | | |  | | | | Drinks/Day | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Drink Beer | |  | | | |  | | | | Cans/Day | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Drink Caffeine | |  | | | |  | | | | Cups/Day | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Use Recreational Drugs | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Exercise | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| Live Alone | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| History of Falls | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| History of Fractures | |  | | | |  | | | |  | | | | | | | | |  | | | | | | |  | | |  | | | | | |
| **IMMUNIZATIONS** | | | | | | | | | | | | | | | | | | | **ALLERGIES** | | | | | | | | | | | | | | | |
|  | | **No** | | | | **Yes** | | | | **Date** | | | | | | | | |  | | | | **No** | | | **Yes** | | **Reaction** | | | | | | |
| Flu Shot | |  | | | |  | | | |  | | | | | | | | | Aspirin | | | |  | | |  | |  | | | | | | |
| Hepatitis B | |  | | | |  | | | |  | | | | | | | | | Banana | | | |  | | |  | |  | | | | | | |
| MMR | |  | | | |  | | | |  | | | | | | | | | Bee Sting | | | |  | | |  | |  | | | | | | |
| Pertussis (Whooping Cough) | |  | | | |  | | | |  | | | | | | | | | Codeine | | | |  | | |  | |  | | | | | | |
| Drug | | | |  | | |  | |  | | | | | | |
| Pneumonia | |  | | | |  | | | |  | | | | | | | | | Hay Fever | | | |  | | |  | |  | | | | | | |
| Tetanus | |  | | | |  | | | |  | | | | | | | | | Latex | | | |  | | |  | |  | | | | | | |
| Zoster (Shingles) | |  | | | |  | | | |  | | | | | | | | | Peanuts | | | |  | | |  | |  | | | | | | |
| **SPIRITUAL/RELIGIOUS PRACTICES** | | | | | | | | | | | | | | | | | | | Penicillin | | | |  | | |  | |  | | | | | | |
|  | | **No** | | | | **Yes** | | | | **Explanation** | | | | | | | | | Shellfish | | | |  | | |  | |  | | | | | | |
| Are there any spiritual/ religious practices or restrictions we should know about in providing your medical care? | |  | | | |  | | | |  | | | | | | | | | Sulfa | | | |  | | |  | |  | | | | | | |
|  | | | | | | | | | Other | | | |  | | |  | |  | | | | | | |
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| **FCHC - PATIENT HEALTH HISTORY FORM**  **PLEASE COMPLETE IN BLACK INK** | | | | | | | | | | | | | | | | | | | | | | | | TODAY’S DATE PAGE 2 | | | | | | | | | | |
| LAST NAME | | | | | | | | | | | LEGAL FIRST NAME | | | | | | | | | | | | | MI | | | | | | DATE OF BIRTH | | | | |
| **Are you being treated by other Healthcare Professionals?** No Yes **If yes, please list doctors & reasons for treatment.**  Physician/Specialist  Dentist  Chiropractor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HOSPITALIZATIONS**  **(NOT INCLUDING NORMAL PREGNANCIES)** | | | | | | | | | | | | | | | | | | | **SERIOUS ILLNESS**  **(NOT REQUIRING HOSPITALIZATION)** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | Year | | | | | |  | | | | | | | | | | | | | Year | | |
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| **PAST SURGERIES** | | | | | | | | | | | | | | | | | | | **PAST ACCIDENTS** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | Year | | | | | |  | | | | | | | | | | | | | Year | | |
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| **FAMILY HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Living** | | **Deceased** | | Year of Birth | | Age | | | Hypertension | | Diabetes | Heart Disease | Stroke | | Mental Illness | Cancer: List Type | | | | | | | | Other Health Issue: List | | | | | | | |
| Father | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Mother | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Father’s Father | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Father’s Mother | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Mother’s Father | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Mother’s Mother | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Son(s) | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Daughter(s) | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| Siblings: | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
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| Spouse | | |  | |  | |  | |  | | |  | |  |  |  | |  |  | | | | | | | |  | | | | | | | |
| **OTHER INFORMATION** | | | | | | | | | | | | | | | | | | | **WOMEN ONLY** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | **No** | | **Yes** | |  | | | | | | | | | | | | | | **No** | **Yes** |
| Last Colonoscopy? |  | | | | | | | Abnormal? | | | | | | |  | |  | | Last Pap Smear? | | | | | |  | | | | Abnormal? | | | |  |  |
| Last Sigmoidoscopy |  | | | | | | | Abnormal? | | | | | | |  | |  | | Last Mammogram? | | | | | |  | | | | Abnormal? | | | |  |  |
| Last Hema-Chek? |  | | | | | | | Abnormal? | | | | | | |  | |  | | Age Periods Started? | | | | | |  | | | | Problems? | | | |  |  |
| Wake in the night to go to the bathroom? | | | | | | | | | | | | | | |  | |  | | Ovarian Cysts? | | | | | | | | | | | | | |  |  |
| Are you currently sexually active? | | | | | | | | | | | | | | |  | |  | | Vaginal itching, burning or discharge? | | | | | | | | | | | | | |  |  |
| Sexual Problems or concerns? | | | | | | | | | | | | | | |  | |  | | Breast lumps, disease or nipple discharge? | | | | | | | | | | | | | |  |  |
| Do you feel safe in your home? | | | | | | | | | | | | | | |  | |  | | Pregnant Now? | | | | | | | | | | | | | |  |  |
| Do you have a Living Will? | | | | | | | | | | | | | | |  | |  | | Planning a Pregnancy? | | | | | | | | | | | | | |  |  |
| If Yes, where is it? | | | | | | | | | | | | | | | | | | | Nursing a Child? | | | | | | | | | | | | | |  |  |
| If No, would you like information on Living Wills? | | | | | | | | | | | | | | |  | |  | | Pregnancies | | | | | | # | | | | Births | | | | # | |
| Have you ever been treated for alcohol abuse? | | | | | | | | | | | | | | |  | |  | | Miscarriages | | | | | | # | | | | Abortions | | | | # | |
| Have you ever been treated for drug abuse? | | | | | | | | | | | | | | |  | |  | | Birth Control Method | | | | | | | | | | | | | | | |
| Do you currently abuse any substances? | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | |  |  |
| Are you under a lot of pressure/stress at work? | | | | | | | | | | | | | | |  | |  | | **MEN ONLY** | | | | | | | | | | | | | | | |
| Are you under a lot of pressure/stress at home? | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | | **No** | **Yes** |
| Have you ever had anesthesia? | | | | | | | | | | | | | | |  | |  | | Last PSA? | | | | | |  | | | | Abnormal? | | | |  |  |
| If Yes, did you have any problems? | | | | | | | | | | | | | | | | | | | Last Prostate Exam? | | | | | |  | | | | Abnormal? | | | |  |  |
| Are you on a special diet? | | | | | | | | | | | | | | |  | |  | | Pain or lump(s) in testicles? | | | | | | | | | | | | | |  |  |
| Are you on any food restrictions? | | | | | | | | | | | | | | |  | |  | | Penile (penis) itching, burning or discharge? | | | | | | | | | | | | | |  |  |
| If Yes, specify | | | | | | | | | | | | | | | | | | | Prostate Disease or problems? | | | | | | | | | | | | | |  |  |
| Have you had a blood transfusion in the past 6 months? | | | | | | | | | | | | | | |  | |  | | Problems starting or stopping your urine stream? | | | | | | | | | | | | | |  |  |

The information on this Patient Health History Form is correct to the best of my knowledge.  
  
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PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE

**Financial Policy**

Thank you for choosing an office of the Fulton County Health Center as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. All patients must complete the required forms and are required to read and sign this Financial Policy prior to any treatment.

***Insurance Companies:*** We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

***Regarding insurance plans where we are a participating provider:*** All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

***Usual and customary rates:*** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of what constitutes a usual and customary rate.

***Injury/Accidents:*** If you are being seen for an injury, please advise the office at the time of scheduling your appointment. Your insurance may require additional information.

***Minor patients:*** The adults accompanying a minor and the parents (or guardians of the minor) are responsible for payment. Unaccompanied minors presenting for non-emergency treatment will be denied if there is no authorization or consent to treat.

***Co-pays and Balances:*** Co-pays are due at the time of service. You will also be asked to pay any outstanding patient balance at the time of an appointment.

***Disability Form Fees:*** You may be charged a fee for completion of forms. Please complete the Patient portion of the form before submitting it to the office staff.

***Remitting Payment:***  Please remit payment to Fulton County Health Center at 735 S Shoop Ave, Wauseon, OH 43567. For your convenience we accept cash, check, Visa, MasterCard and Discover.

***Insufficient Fund Fee:*** Checks that are returned will be charged a $30.00 insufficient funds fee.

Please let us know if you have any questions or concerns.

**I have read the *Financial Policy* and I understand and agree to its provisions.**

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