AULTMAN
ORRVILLE
DUNLAP
FAMILY PHYSICIANS

New Patient Packet

Welcome to Aultman Orrville Dunlap Family Physicians! We are committed to providing healthcare of the highest quality to every patient every day and improving the health and education of the community.

Enclosed is a patient data sheet which has been pre-populated with the information we currently have on file. Please review this form for accuracy and make any corrections we need to make in our practice management system.

If you are a new patient to the practice, we have also enclosed a Health History Form. This information is used to build your medical record and also to collect information about any screening testing that you may need.

Aultman Orrville Dunlap Family Physicians does not offer chronic pain management. We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.

We have also provided you with a copy of our Financial Policy, Notice of Privacy Practices Signature Sheet (policy available on website and at office) and Privacy Communication Worksheet. There is also a Release of Information Form if you are transferring from another practice which will allow us to obtain your medical records.

We encourage you to review the enclosed brochure explaining our patient portal. Using the secure online portal, you will be able to schedule non-emergent appointments, request prescription refills, and send patient messages to the physicians. The physicians can send messages, replies, results, and orders to the portal for you to review and print out if needed. **Please consider signing up at your first appointment by filling out the enrollment form beforehand.**

Thank you for becoming a new patient. Please have this new patient information packet filled out **COMPLETELY** and return 2 business days prior to your appointment, and arrive 20 minutes prior to your appointment to complete the registration process. ***Failure to return paperwork in the time frame noted above may result in having to reschedule your appointment.***

You must bring your updated **Insurance Card, Photo ID,** and **co-payment.** ***Failure to do so may result in having to reschedule your appointment.***

At future appointments all copays and account balances will be collected at the time of service unless you have set up a payment program with the billing department.

Patients without Insurance

We are happy to work with self-pay patients and our policy requires payment in full at the time of service and/or prior to service for certain procedures. Self-pay patients do receive a discount.

Thank you for choosing Aultman Orrville Dunlap Family Physicians for your healthcare needs. We look forward to seeing you!

Sincerely,

Aultman Orrville Dunlap Family Physicians

AULTMAN ORRVILLE DUNLAP FAMILY PHYSICIANS

PATIENT INFORMATION		FINANCIAL RESPONSIBILITY INFO	
Patient Name:		**Insurance Guarantor:**	
Address:		**Address:**	
Address 2:		**Address 2:**	
City, St, ZC		**City, St, ZC**	
Home Phone:		**Home Phone:**	
Work Phone:		**Work Phone:**	
Cell Phone:		**Cell Phone:**	
Birth Date:		**Birth Date:**	
Employer:		**Employer:**	
Med Rec No			
Marital Status			
Patient E-Mail Address		**Guarantor E-Mail Address**	

Emergency Contact Name:	
Emergency Contact Number"	
Referred By:	
Other Physicians:	
PHARMACY NAME:	
Pharmacy Telephone:	

	PRIMARY INSURANCE	***SECONDARY INSURANCE***
Company Name		
Policy Holder Name		
Policy Holder Date of Birth		
Policy ID Number		
Group Number/Name		
Relationship to Policy Holder	Self Spouse Child Other	Self Spouse Child Other
Copay Amount		

****PLEASE READ SIGN WHERE INDICATED BELOW****

Patient Financial Responsibility and Assignment of Benefits:

I authorize Aultman Orrville Dunlap Family Physicians ("AOH DFP") to bill my insurance or health plan, including Medicaid and/or Medicare, for the services that AOH DFP provides me and I hereby assign the payment of any medical benefits under such insurance or health plan to AOH DFP. I further authorize AOH DFP to release my medical and other information as necessary to obtain payment for services provided to me by AOH DFP. I understand that I am responsible for any and all payment obligations arising out of the care, treatment and services provided to me by AOH DFP, including deductibles, co-payments and any other patient responsibility under my insurance policy or for any service that is not covered by my insurance. I understand that co-payments, deductibles and other payments may be due on the date of my appointment or service and that AOH DFP will collect such payment before services are provided to me. I understand that I have a right to review AMG's Patient Account/Financial Policy and that I may direct questions about this policy to AMG's Patient Accounts Department. I recognize that AOH DFP's policies may change from time to time, without notice to me.

Consent to Treatment:

I hereby voluntarily consent to receive treatment and services at Aultman Orrville Dunlap Family Physicians. I give my permission to AOH DFP and to my physician (or my health care provider) to administer any service or treatment deemed necessary or advisable. I also specifically consent to medical procedures and tests determined necessary to assist in my diagnosis and treatment.

HIPAA ACKNOWLEDGMENT: I hereby acknowledge that I received, or was offered, a copy of AOH's Notice of Privacy Practices which describes how my health information may be used and disclosed by AOH DFP and which outlines my rights with respect to my health information as created and maintained by AOH DFP.

Patient or Patient Representative Signature		**Witness**	
Today's Date:			

AULTMAN
ORRVILLE
DUNLAP
FAMILY PHYSICIANS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Date: _____
MRN: _____
Patient Name: _____
Date of Birth: _____

I hereby acknowledge that on_____ (date). I received or was offered a copy of the Notice of Privacy Practices of Aultman Orrville Dunlap Family Physicians which sets forth the ways in which my health information may be used or disclosed by Aultman Orrville Dunlap Family Physicians and outlines my rights with respect to such information.

_____

Signature of Patient or Patient's Representative Date/Time

STAFF SHOULD COMPLETE IF ACKNOWLEDGEMENT FORM IS NOT SIGNED:

1. Did patient receive a copy of the Privacy Notice? Yes No
1. Below explain why the patient did not sign the acknowledgement form and/or explain the efforts in trying to obtain the patient's signature (check all that apply)

___ Patient unable to comprehend
___ Patient communication barrier
___ Legal Representative not available
___ Patient offered and refused copy of NPP
___ Other:
___ Patient/Legal Representative left before signature obtained
___ Emergency Admission/Patient not present for registration
___ Patient refused to sign
___ Patient states they have already received a copy of Aultman Orrville Dunlap Family Physicians NPP

_____

Completed by:

_____

Signature of Workforce Member Date/Time

AULTMAN ORRVILLE DUNLAP FAMILY PHYSICIANS

PRIVACY COMMUNICATION WORKSHEET

Today's Date _____
MRN _____
Patient Name _____
Date of Birth _____

Designated person(s) to whom we may share PHI (Protected Health Information):

Name:		Relationship:		Telephone:	
Name:		Relationship:		Telephone:	
Name:		Relationship:		Telephone:	

Comments:			
Initials of employee completing this section:		Department/Office	

Requested Restriction(s) for Uses and Disclosures:

Comments:			
Initials of employee completing this section		Department/Office	

I understand that Aultman Orrville Dunlap Family Physicians cannot guarantee this restriction request, but that they are required to attempt to accommodate reasonable requests when appropriate. I further understand that Aultman Orrville Dunlap Family Physicians reserves the right to terminate an agreed-to-restriction if it feels that termination is appropriate; and that I also have the right to terminate, in writing, any restrictions by completion of this form on a subsequent date.			
Alternative Communication Request(s)			
Patient Signature:		Date:	
Staff Signature:		Date:	

AULTMAN ORRVILLE DUNLAP FAMILY PHYSICIANS

Authorization for Release of Health Information

Name of Individual/Maiden/AKA (Last, First, MI)	*Date of Birth*	*Medical Record Number*

☐ Emergency Department	☐ Radiology Reports	☐ Operative Reports	☐ Complete Medical Record
☐ Lab Reports	☐ Pathology Reports	☐ Discharge Summary	☐ Office Notes
☐ Billing Reports	☐ History & Physical	☐ EKG	☐ Medication Records
☐ Research Records	☐ Other (Specify in detail):_____		

I would like: ☐ To inspect medical records ☐ A copy of medical records

Reason for Disclosure: ☐ At the request of the patient ☐ Other (describe):

This information may be released from:		**This information may be disclosed to:**	
		AULTMAN ORRVILLE DUNLAP FAMILY PHYSICIANS	
Organization or healthcare providing making disclosure		*Individual or organization receiving information*	
		830 S. Main St	
Address		*Address*	
		Orrville, OH 44667	
City, State, Zip Code		*City, State, Zip Code*	
		(330) 684-2015	**330-684-1649**
Phone Number	***Fax Number***	***Phone Number***	***Fax Number***

I hereby authorize the use or disclosure of personal health information about me as described above. I understand if a request to inspect the record is made, nothing may be removed, taken apart, or noted in or on any portion of the medical record. 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 a person or entity and will likely no longer be protected by the federal privacy regulations. As described in the Notice of Privacy Practices of Aultman, I understand that I may revoke this authorization in writing any time, except to the extent that action has been taken by Aultman in reliance on this authorization, by sending a written revocation to **Aultman Orrville Dunlap Family Physicians, 830 S Main St., Orrville OH 44667.** Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand this authorization is voluntary and Aultman will not condition treatment, payment, enrollment or eligibility for benefits on this authorization. I understand and acknowledge that my medical record may contain information relating to Mental Health, Alcohol/Drug Abuse and/or Human Immune Virus/Acquired Immune Deficiency Syndrome, or other sensitive information, and I expressly consent to the release of any such information contained in the record designated above. This release is sufficient for the purpose of release of Alcohol/Drug diagnosis and treatment, HIV test results or diagnosis.

Signature:	
Date:	

If the personal representative of the individual is signing this authorization, please attach document(s) of the personal representative's authority to act on behalf of the individual, if any:

Patient Representative's Signature:	
Date:	
Description Authority:	

AULTMAN
ORRVILLE HOSPITAL

Patient Rights & Responsibilities

EVERY PATIENT HAS THE RIGHT TO:

1. Be notified of his or her rights in a language or manner that the patient can understand.
1. Be treated with courtesy and respect.
2. Be informed of patient rights in advance of providing or discontinuing care whenever possible.
3. Make informed decisions about his or her care and to participate in the development and implementation of his or her plan of care, including the discharge plan and pain management plan.
4. Know whom to contact with a grievance and have prompt resolution of any and all grievances.
5. Communicate freely with other and to interact socially, unless specifically restricted in his or her treatment plan for clear treatment reasons.
6. Formulate advance directives and to have practitioners comply with these directives.
7. Have a family member or representative of his or her choice and his or her own physician notified promptly upon admission to the hospital.
8. Get important information about his or her care in his or her preferred language and/or in a manner that meets his or her needs, if he or she has vision, speech, hearing or mental impairments.
9. Refuse care.
10. Free exercise of religious worship within the facility. No patient will be coerced into engaging in any religious activity.
11. Have his or her pain addressed.
12. Know the names of caregivers who are treating him or her.
13. Know when something goes wrong with his or her care.
14. Get a list of all his or her current medications.
15. Personal privacy.
16. Receive care in a safe setting.
17. Be free from all forms of abuse or harassment.
18. The confidentiality of his or her clinical records.
19. Access information contained in his or her clinical records within a reasonable time frame.
20. Receive a copy of a reasonable clear and understandable itemized bill, and upon request, to have charges explained.
21. Be free from physical or mental abuse, and corporal punishment.
22. Be free from restrain or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.
23. Be informed of his or her visitation rights, including any clinical restriction or limitation on such rights.
24. Not have visitation rights of any individual restricted, limited or otherwise denied or reduced on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.
25. Have the hospital accept his or her designation, orally or in writing of a support person.

PATIENT EDUCATION

EVERY PATIENT IS RESPONSIBLE FOR:

1.Providing, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, and other matters relating to his or her health.
2. Asking questions when they do not understand what they have been told about their care, treatment, or service or what they are expected to do.
3. Making it known to the appropriate people whether he or she clearly understands a contemplated course of action and what is expected.
4. Following all instructions given by their physicians and staff.
5. The outcomes of their actions if they refuse treatment or do not follow practitioner's instructions.
6.Promptly meeting any financial obligation agreed to with the hospital
7. Being considerate of the hospital's staff and property, as well as hospital.
8. Being considerate of the rights of other patients and personnel and assist in the control of noise, smoking, and a number of visitors.
9. Complying with posted visitor's hours as they pertain to their visitors.
10. Honoring the designation of the hospital and campus as smoke-free.
11. Immediately reporting any allegations of abuse, neglect harassment, or exploitation to the physician or nurse in charge, risk management department, or administration.
12. Following the hospital's rules and regulations.

PATIENT COMPLAINS MAY BE DIRECTED TO THE FOLLOWING PERONS AND ANGENCY:

Aultman Patient Relations Representative
832 South Main St
Orrville, Ohio 44667
Phone: 330-684-4734
Online: www.aultmanorrville.org

Ohio Department of Health
Health Care Facility Complaint Department
246 North High St
Columbus, Ohio 43215
Complaint Hotline: 1-800-342-0553
Email: HCComplaints@odh.ohio.gov

The Joint Commission
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Online: www.jointcommission.org
Email: complaint@jointcomission.org

I acknowledge that I was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms I could understand.

Form 202923AOH D: 12/17

Date **Time** **Patient Signature**

AULTMAN ORRVILLE DUNLAP FAMILY PHYSICIANS
HEALTH HISTORY FORM

Patient Name:		Patient DOB:		Date	

Relationship Status:	□ **Married** □ **Single** □ **Separated** □ **Divorced** □ **Widowed** □ **Life Partner**
Children:	□ **Yes** □ **No**
Education:	□ **Some High School** □ **High School Graduate** □ **Some College** □ **College Grad**

HEALTH PARTNERS	Names of your other physicians?	What is their specialty?

ALLERGIES/REACTION: (Please list food, drug and latex allergies)		
1.	Reaction:	
2.	Reaction:	
3.	Reaction:	
Additional allergies:		

MEDICATIONS (Prescriptions, over the counter, herbal preparations and supplements)

Medication Name	Dosage	Frequency	Route (oral/IM)	Reason	Ordering Physician
Failed Medications:					

PREVIOUS HOSPITALIZATIONS AND SURGERIES

Reason for hospitalization	Date	Name of Surgeon

BEHAVIORAL RISKS/SOCIAL HISTORY

Tobacco Use:	□ Never Smoked or chewed tobacco □ Former Smoker (How long ago? ____ yrs)
	□ Current Cigarette Smoker □ Current Cigar Smoker □ Current Chewing Tobacco How much per day? __ How many years? __
Alcohol Use:	□ Never □ Occasionally □ Moderate □ Heavy Amount per day/week/month
Caffeine Use:	□ Never □ Number of Cups/Can Daily? _____ □ Coffee □ Tea □ Carbonated Beverages □ Other_____
Drug Use:	□ Never □ Past Use □ Currently using drugs? What drug(s)? _____
Tattoos/Piercings	□ Single □ Multiple Locations:

Patient Name:		Patient DOB:		Date	

PERSONAL & FAMILY MEDICAL HISTORY (Check all that apply)			
			List Cause of Death
Is your mother alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your father alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your maternal grandmother alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your maternal grandfather alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your paternal grandmother alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	
Is your paternal grandfather alive?	**□ Yes**	**Age: _____**	
	□ No	**Age at Death: _____**	

		Is there a family history? If yes, please check who								
	Self	Mom	Dad	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Child
Alcoholism										
Anemia										
Arthritis										
Asthma										
Barium X-rays										
Bladder infections/stones										
Blood Clots										
Broken Bones. Where:										
Bronchitis										
Cancer: Type:										
Addt'l Info for Cancer:										
Concussion										
Diabetes: Type:										
Drug Abuse										
Depression										
Epilepsy/Seizures										
Gallbladder disease										
Glaucoma										
Hair Loss										
Head Injury										
Heart catheterization										
Heart Disease										
Addt'l Info for Heart Disease:										

Patient Name:		Patient DOB:		Date	

	Self	Mom	Dad	Brother	Sister	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Child
Hepatitis										
High Blood Pressure										
High Cholesterol										
HIV/Immune DX										
Kidney infections/stones										
Kidney disease										
Liver Disease										
Hepatitis										
Lung Disease										
Mental illness										
Migraines										
Mononucleosis										
Moodiness										
Osteoarthritis										
Osteoporosis										
Pain (location:)										
Phlebitis (inflammation of vein)										
Pneumonia										
Rheumatic Arthritis										
Rheumatic Fever										
Seizures										
Sprains										
Stroke										
Suicide Attempt										
Thyroid Disease										
Tuberculosis										
Ulcer in GI Tract										
Venereal Disease										
Whiplash										

Is there any medical history with your brothers, sisters, children, parents or grandparents not captured above?

Patient Name:		Patient DOB:		Appt. Date:	

REVIEW OF SYSTEMS

Y	N	?	GENERAL
			Weight gain in the last year
			Weight loss in the last year
			Fevers, chills or sweats
			Change in appetite
			Extreme fatigue
Y	N	?	SKIN
			Rashes
			Ulcers
			Dryness
			Scaling
			Sores
			Slow healing
			Abnormal hair loss
			Unusual moles
Y	N	?	HEAD
			Headaches
			Dizziness
			Vertigo
Y	N	?	EYES
			Wear glasses/contacts
			Blurred/Double vision
			Blind spots
			Loss of peripheral vision
			Pain
			Itching
			Redness, drainage or crusting
			Injuries
Y	N	?	EARS
			Changes in hearing
			Ringing in ears
			Pain
			Drainage
			History of frequent infections
			Injuries
Y	N	?	NOSE
			Nosebleed
			Sinus drainage
			Runny Nose
			Post Nasal Drip
			Stuffy Nose
			Sneezing/Allergies
Y	N	?	THROAT
			Pain or sore
			Hoarseness
			Difficulty swallowing
Y	N	?	NECK
			Thyroid problems
			Goiter
			Swollen glands

Y	N	?	MOUTH
			Sores or ulcers in mouth or tongue
			Sores on lips
			Dental problems
			False teeth
			Problems with false teeth
			Bleeding of gums
Y	N	?	HEMATOLOGIC
			Anemia
			Sickle cell anemia
			Easy bruising from skin
			Problems with excessive bleeding
Y	N	?	RESPIRATORY
			Exposure to someone with TB
			Wheezing
			Shortness of breath
			Chronic cough
			Phlegm or sputum
			Coughing up blood
Y	N	?	CARDIOVASCULAR
			Chest pain/heaviness
			Palpitations/Abnl heart rate
			High blood pressure
			Heart murmur
			Shortness of breath with exertion
			Waking up with shortness of breath
			Trouble breathing lying flat
			Varicose veins
			Leg pain with walking
			Leg cramps
			Swelling of legs or ankles
Y	N	?	GASTROINTESTINAL
			Ulcers
			Frequent nausea
			Frequent vomiting
			Diarrhea or loose stools
			Constipation
			Hemorrhoids
			Rectal bleeding
			Black stools
			Alcohol use
			Abdominal pains or cramps

Patient Name:		Patient DOB:		Appt. Date:	

REVIEW OF SYSTEMS (CONT'D)

Y	N	?	ORTHOPEDIC	
			Muscle aches	
			Muscle spasms	
			Severe sprains	
			Joint pain, stiffness or swelling	
			Back problems	
Y	N	?	NEUROLOGIC	
			Numbness	
			Weakness or paralysis	
			Passing out or loss of consciousness	
			Tingling	
			Worsening memory	
			Difficulty concentration	
Y	N	?	ENDOCRINE	
			Excessive thirst	
			Excessive urination	
			Decreased sex drive	
			Thyroid problems	
			Sensitive to heat or cold	
			Other hormone problems	
Y	N	?	GYNECOLOGIC	
			Age started period	
			Change in life (menopause)	
			Irregular periods	
			Pregnancies	
			Deliveries	
			Miscarriages	
			Discharge	
			Spotting	
			Breast discharge or milk	
			Irregular vaginal bleeding	
			Vaginal itching	
Y	N	?	OTHER	
			Moving legs a lot at night	
			Genital Warts	
			Genital Herpes	

			Sexually Transmitted Disease	
			Multiple sexual partners	
Y	N	?	MEN ONLY	
			Difficulty gaining erections	
			Difficulty maintain erections	
			Testicular lumps	
			Do you perform testicular self-exams?	
Y	N	?	WOMEN ONLY	
			Breast pain or lumps	

RECOMMENDED SCREENING/PREVENTIVE SERVICES

	Date
Last Physical Examination	
Last Dental Visit	
Colonoscopy	
EGD (Scope of esophagus, stomach, small bowel	
Pap Smear	
Mammogram	
Tetanus Booster	
Zostavax (shingles vaccine/chicken pox)	
Pneumovax	
Prevnar (Pneumonia Booster)	
Influenza Vaccine	
Cholesterol Screening	
Bone Density (Females)	
PSA (Prostate Specific Antigen (Males)	
Eye Exam	

DIABETIC PATIENTS ONLY

	Date	Provider Name
Last Retinal Eye Exam		
Last Foot Exam by Podiatrist		

HEARING ASSESSMENT (If you are 18 to 64 years old, the following questions will help you determine if you need to have your hearing evaluated by a health professional)		
Do you currently have hearing aids (If yes, skip this section)	□ Yes	□ No
Does a hearing problem cause you to feel embarrassed when you meet new people?	□ Yes	□ No
Do you have difficulty hearing or understanding co-workers, clients, or customers?	□ Yes	□ No
Do you fell slowed down by a hearing problem?	□ Yes	□ No
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	□ Yes	□ No
Does a hearing problem cause you difficulty in the movies or in the theater?	□ Yes	□ No
Does a hearing problem cause you to have arguments with family members?	□ Yes	□ No
Does a hearing problem cause you difficulty when listening to TV or radio?	□ Yes	□ No
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	□ Yes	□ No
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	□ Yes	□ No
If you answered "Yes" to three or more of these questions, you may want to see an audiologist (a hearing specialist) for a hearing evaluation. Ask us for a referral.		

Patient Signature: _____ Date: _____

Physician Review: _____ Date: _____