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. We require everyone who enters the building to wear a face mask/covering. 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**

Ann M. Steck, MD
Elizabeth A. Barga, DO
Hayley L. Baldwin, NP-C
Paul T. Diaz, NP

**Address**

6696 US Highway 20A Delta, OH 43515

**Office Phone**

(419) 822-3242

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

**Office Fax**

(419) 330-2641

**Office Hours**

Monday-Friday 7:45 am – 5:00 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**

fchcprimarycaredelta.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 |

FCHC Medical Group 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 FCHC Medical Group, all healthcare facilities must comply.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sexual Orientation: | ❑ Straight | ❑ Bisexual | ❑ Lesbian/Gay/Homosexual | ❑ Don’t Know | ❑ Declined |
| Gender Identity: | ❑ Male | ❑ Female | ❑ Trans Male (F to M) | ❑ Trans Female (M to F) | ❑ Non-Binary |
| ❑ Declined | ❑ Other |  |  |  |  |

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FCHC Medical Group 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

|  |  |
| --- | --- |
| **FCHC Medical Group - 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 Medical Group - 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/SpecialistDentistChiropractor |
| **HOSPITALIZATIONS** **(NOT INCLUDING NORMAL PREGNANCIES)** | **SERIOUS ILLNESS** **(NOT REQUIRING HOSPITALIZATION)** |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
| **PAST SURGERIES** | **PAST ACCIDENTS** |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
| **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: |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 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? |  |  |

**PHI Release Authorization**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this authorization form, you are agreeing to the release or disclosure of your protected health information. Your medical care or payment for care will not be conditioned on the signing of this form.

Please be aware that any information disclosed to a third party pursuant to this authorization may be subject to re-disclosure and no longer protected by our policies and applicable law.

This authorization will expire one year from the date of the signature below. You have the right to revoke this authorization by completing the revocation section below. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release my protected health information to:

❑ FCHC Primary Care Delta ❑ FCHC Primary Care Fayette ❑ FCHC Primary Care Wauseon
 6696 US Highway 20A 124 W Main St, PO Box 399 735 S Shoop Ave
 Delta, OH 43515 Fayette, OH 43521 Wauseon, OH 43567
 Phone: 419-822-3242 Phone: 419-237-2501 Phone: 419-335-3242
 Fax: 419-330-2641 Fax: 419-237-2671 Fax: 419-335-3222

❑ FCHC Orthopedics ❑ FCHC OB/GYN ❑ FCHC Pediatrics
 735 S Shoop Ave 725 S Shoop Ave 725 S Shoop Ave
 Wauseon, OH 43567 Wauseon, OH 43567 Wauseon, OH 43567
 Phone: 419-335-2663 Phone: 419-335-6377 Phone: 419-335-3333
 Fax: 419-335-9615 Fax: 419-335-6807 Fax: 419-337-7845

❑ FCHC Behavioral Health ❑ FCHC General Surgery ❑ FCHC Urology
 725 S Shoop Ave 725 S Shoop Ave 725 S Shoop Ave
 Wauseon, OH 43567 Wauseon, OH 43567 Wauseon, OH 43567
 Phone: 419-330-2790 Phone: 419-337-7478 Phone: 419-335-2000
 Fax: 419-330-2774 Fax: 419-337-7846 Fax: 419-335-7500

❑ FCHC Urgent Care ❑ FCHC Cardiology ❑ FCHC Ear, Nose & Throat
 735 S Shoop Ave 725 S Shoop Ave 725 S Shoop Ave
 Wauseon, OH 43567 Wauseon, OH 43567 Wauseon, OH 43567
 Phone: 419-337-7467 Phone: 419-335-330-2769 Phone: 419-335-3712
 Fax: 419-337-7468 Fax: 419-330-2738 Fax: 419-335-3713

The information to be disclosed may include information related to diagnosis and treatment for HIV, alcohol and/or substance abuse and mental illness.

Information and date(s) of service to be disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Purpose for disclosure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient/Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*Revocation\*\*\* (Sign below ONLY if you wish to revoke this authorization)**

I hereby revoke this authorization

Patient/Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_