

Welcome to



Providers

Ann M. Steck, MD
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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

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.



Pediatric Patient Registration Form

Last Name _____ First Name _____ MI _____ Date of Birth _____

Birth Sex Male Female SS# _____ - _____ - _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Parent/Guardian _____ Phone (____) _____ Text Reminders Yes No

Parent/Guardian _____ Phone (____) _____ Home Phone (____) _____

Appointment Reminders – Check One Call Mom Call Dad Text Mom Text Dad Call Home Phone

Primary Language English Spanish ASL Other _____ Interpreter Needed Yes No Marital Status _____

Primary Care Physician _____ Pharmacy/City _____

| | | | |
|------------|---|--|---|
| Race: | <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American |
| | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | <input type="checkbox"/> White | <input type="checkbox"/> Other <input type="checkbox"/> Unknown |
| Ethnicity: | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Not Hispanic/Latino | <input type="checkbox"/> Unknown |

Guarantor – Person Financially Responsible

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 _____

Authorization to Treat a Minor (Ages 0-18th Birthday):

If there are circumstances when I am unable to bring my child to the office for his/her appointment, I authorize for the following persons (over the age of 18) to obtain medical care for my child. I authorize the providers and staff of FCHC Medical Group to discuss my child’s personal health information, appointment, insurance, test results and medical care to those listed below.

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

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

Patient/Authorized Representative Signature

Date



Pediatric 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.

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



Pediatric Intake/Health History Form

Last Name _____ First Name _____ MI _____ Date of Birth _____

CHILD’S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER _____

MEDICINES/VITAMINS _____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Where was your child born (Hospital/City)? _____

Is the child yours by: Birth Adoption Stepchild Other _____

Please indicate any medical problems during pregnancy: None Specify: _____

Delivery by: Vaginal birth Caesarean If Caesarean, why? _____

Birth weight: _____ Birth length: _____

Please indicate any medical problems during the baby’s newborn period:

None If premature, How early? _____ Other problems: _____

NUTRITION & FEEDING

Was/is your child breastfed? Yes No If yes, how long? _____

If your child is breastfed, are they on Vitamin D Supplement? Yes No

Has your child had any feeding/dietary problems? Yes No If yes, specify: _____

Milk intake now: Type: Cow’s Milk (Nonfat 1% fat 2% fat Whole milk) Soy Milk Rice Milk Other _____

Average ounces per day (Note 8 ounces = 1 cup) _____

SLEEP

Hours per night _____ Naps (number & length) _____

Any sleep problems? _____

DEVELOPMENT

At what age did your child: Sit Alone _____ Walk Alone _____ Say Words _____ Toilet Train (daytime) _____

Girls only: Age at first menstrual period _____

Any concerns about your child’s behavior or development? Yes No

DENTAL HISTORY

Has your child been seen by a dentist? Yes No Dentist _____

If so, how often? _____ Date of last visit _____ Water Source: City Well Other _____

SCHOOL HISTORY

Name of School _____ Grade _____

Any concerns about school performance? _____

Any concerns about relationship with: Teachers Yes No Student Yes No

Pediatric Intake/Health History Form

Last Name _____ First Name _____ MI _____ Date of Birth _____

SAFETY

When your child is in the car, does he/she use: An infant seat Booster Seat Seatbelt

Do you have smoke detectors in your home? Yes No

Does your child wear a helmet for a Bike/Scooter or ATV? Yes No

Do any members in the household smoke or use tobacco? Yes No

Are there any guns in the home? Yes No

Is there any violence in the home? Yes No

IMMUNIZATIONS

Has your child had immunizations? Yes No Where? _____

Has your child had? Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB)

SOCIAL HISTORY

Who lives at home?

| Name | Age | Relationship | Name | Age | Relationship |
|-------|-------|--------------|-------|-------|--------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Are your child's parents: Married Unmarried Separated Divorced

Child care: Parents Daycare Other _____

Concerns about your child: None Alcohol Use Drug Use Tobacco Sexual Activity Aggressive Behavior

Are there any pets in the home? Yes No I so what pet? Dog(s) Cats(s) Other

TV-hours per day _____ Computer hours per day _____ Video games hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates. _____

Other Physicians or Specialists your Child sees (Names and specialty) _____

Hospitalizations/operations (with dates) _____

Broken bones or severe sprains: _____

FAMILY HISTORY

Please check below if any immediate (parent, sibling, or grandparent) family members have any of the listed conditions:

Alcoholism

Heart Attack

Other _____

Cancer Type _____

High Blood Pressure

Other _____

Depression/Suicide

High Cholesterol

Diabetes

Stroke



Pediatric Review of Symptoms

Last Name _____ First Name _____ MI _____ Date of Birth _____

REVIEW OF SYMPTOMS: Please circle any current problems your child has on the list below:

Constitutional

Fever/chills/excessive sweating
Unexplained weight loss/gain

Eyes

Squinting/crossed eyes

Ears/Nose/Throat

Unusually loud voice/hard of hearing
Mouth breathing/snoring
Bad Breath
Frequent runny nose
Problems with teeth/gums

Cardiovascular

Tires easily with exercise
Shortness of breath
Fainting

Respiratory

Cough/Wheeze
Chest Pain

Gastrointestinal

Nausea/vomiting/diarrhea
Constipation
Blood in Bowel Movement

Genitourinary

Bedwetting
Pain with urination
Discharge: penis or vagina

Musculoskeletal

Muscle/joint pain

Skin

Rashes
Unusual moles

Neurological

Headaches
Weakness
Clumsiness

Psychiatric/Emotional

Speech problems
Anxiety/stress
Problem with sleep/nightmares
Depression
Nail biting/thumb sucking
Bad temper/jealousy

Blood/Lymph

Unexplained lumps
Easy bruising/bleeding

Allergy

Hay Fever/itchy eyes



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:

- | | | |
|--|--|--|
| <input type="checkbox"/> FCHC Primary Care Delta 6696 US Highway 20A Delta, OH 43515 Phone: 419-822-3242 Fax: 419-822-9008 | <input type="checkbox"/> FCHC Primary Care Fayette 124 W Main St, PO Box 399 Fayette, OH 43521 Phone: 419-237-2501 Fax: 419-237-2671 | <input type="checkbox"/> FCHC Primary Care Wauseon 735 S Shoop Ave Wauseon, OH 43567 Phone: 419-335-3242 Fax: 419-335-3222 |
| <input type="checkbox"/> FCHC Orthopedics 735 S Shoop Ave Wauseon, OH 43567 Phone: 419-335-2663 Fax: 419-335-9615 | <input type="checkbox"/> FCHC OB/GYN 725 S Shoop Ave Wauseon, OH 43567 Phone: 419-335-6377 Fax: 419-335-6807 | <input type="checkbox"/> FCHC Pediatrics 725 S Shoop Ave Wauseon, OH 43567 Phone: 419-335-3333 Fax: 419-337-7845 |
| <input type="checkbox"/> FCHC Behavioral Health 725 S Shoop Ave Wauseon, OH 43567 Phone: 419-330-2790 Fax: 419-330-2774 | <input type="checkbox"/> FCHC General Surgery 725 S Shoop Ave Wauseon, OH 43567 Phone: 419-337-7478 Fax: 419-337-7846 | <input type="checkbox"/> FCHC Urology 725 S Shoop Ave Wauseon, OH 43567 Phone: 419-335-2000 Fax: 419-335-7500 |
| <input type="checkbox"/> FCHC Urgent Care 735 S Shoop Ave Wauseon, OH 43567 Phone: 419-337-7467 Fax: 419-337-7468 | <input type="checkbox"/> FCHC Heart & Vascular 725 S Shoop Ave Wauseon, OH 43567 Phone: 419-335-330-2653 Fax: 419-330-2656 | |

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: _____