Welcome to

FCHC Medical Group

FCHC Primary Care Delta

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

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.

FCHC Medical Group

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

FCHC Medical Group

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
CARDIOVASCULAR			
Drug Allergies			
Hay Fever			
Latex Allergy			
High Blood Pressure			
Low Blood Pressure			
Palpitations			
Varicose Veins			
CONSTITUTIONAL			
Chills			
Fatigue or Weakness			
Fever			
Headache (Frequent)			
Weight Gain			
Weight Loss			
EAR/NOSE/THROAT			
Difficulty Hearing			
Ear Infections			
Ringing Ears			
Sinus Trouble			
Sore Throat			
ENDOCRINE			
Cold Intolerance			
Excessive Thirst			
Heat Intolerance			
Thyroid Trouble			
Tired/Sluggish			

Check all items either No or Yes	No	Yes, Now	Yes, Past
EYES			
Blurred Vision			
Double Vision			
Eye Pain			
Failing Vision			
Vision Loss			
GASTROINTESTINAL			
Abdominal Pain			
Appetite Loss			
Blood in Stool			
Constipation			
Diarrhea			
GI Bleed			
Indigestion/Heartburn			
Nausea/Vomiting			
Ulcers/Reflux/GERD			
GENITOURINARY			
Bladder Leakage			
Blood in Urine			
Painful Urination			
Urinary Frequency			
Urine Retention			
HEMATOLOGIC/LYMPHATIC			
Abnormal Bleeding			
Bleeding Disorders			
Blood Clotting Problems			
Swollen Glands			

Check all items either No or Yes	No	Yes, Now	Yes, Past
INTEGUMENTARY/SKIN			
Boils/Lesions			
Persistent Itch			
Skin Rash			
MUSCULOSKELETAL			
Back Pain			
History of Falls			
History of Fractures			
Joint Pain			
Neck Pain			
NEUROLOGICAL			
Dizzy Spells			
Memory Loss			
Numbness/Tingling			
Seizures			
Stroke			
Tremors			
PSYCHIATRIC			
Anxiety			
Depression			
Difficulty Sleeping			
RESPIRATORY			
Difficulty Breathing			
Frequent Cough			
History/Exposure TB			
Shortness of Breath			
Wheezing			

HABITS/SOCIAL HISTORY

Do you:	No	Yes	If Yes, how much?
Smoke Tobacco			Packs/Day
Chew Tobacco			Tins or Bags/Day
Did you Smoke?			Year Quit
How many years did you smoke?			Packs/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			

MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.)

What pharmacy do you use?

Medication	Dosage	How many times a day?

IMMUNIZATIONS

	No	Yes	Date
Flu Shot			
Hepatitis B			
MMR			
Pertussis (Whooping Cough)			
Pneumonia			
Tetanus			
Zoster (Shingles)			

SPIRITUAL/RELIGIOUS PRACTICES

	No	Yes	Explanation
Are there any spiritual/ religious practices or restrictions we should know about in providing your medical care?			

ALLERGIES

	No	Yes	Reaction
Aspirin			
Banana			
Bee Sting			
Codeine			
Drug			
Hay Fever			
Latex			
Peanuts			
Penicillin			
Shellfish			
Sulfa			
Other			

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/Specialist
Dentist
Chiropractor

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			No	Yes
Last Colonoscopy?		Abnormal?		
Last Sigmoidoscopy		Abnormal?		
Last Hema-Chek?		Abnormal?		
Wake in the night to go to the bathroom?				
Are you currently sexually active?				
Sexual Problems or concerns?				
Do you feel safe in your home?				
Do you have a Living Will?				
If Yes, where is it?				
If No, would you like information on Living Wills?				
Have you ever been treated for alcohol abuse?				
Have you ever been treated for drug abuse?				
Do you currently abuse any substances?				
Are you under a lot of pressure/stress at work?				
Are you under a lot of pressure/stress at home?				
Have you ever had anesthesia?				
If Yes, did you have any problems?				
Are you on a special diet?				
Are you on any food restrictions?				
If Yes, specify				
Have you had a blood transfusion in the past 6 months?				

WOMEN ONLY				No	Yes
Last Pap Smear?		Abnormal?			
Last Mammogram?		Abnormal?			
Age Periods Started?		Problems?			
Ovarian Cysts?					
Vaginal itching, burning or discharge?					
Breast lumps, disease or nipple discharge?					
Pregnant Now?					
Planning a Pregnancy?					
Nursing a Child?					
Pregnancies	#	Births	#		
Miscarriages	#	Abortions	#		
Birth Control Method					

MEN ONLY				No	Yes
Last PSA?		Abnormal?			
Last Prostate Exam?		Abnormal?			
Pain or lump(s) in testicles?					
Penile (penis) itching, burning or discharge?					
Prostate Disease or problems?					
Problems starting or stopping your urine stream?					

FCHC Medical Group

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
6696 US Highway 20A
Delta, OH 43515
Phone: 419-822-3242
Fax: 419-330-2641

❑ FCHC Primary Care Fayette
124 W Main St, PO Box 399
Fayette, OH 43521
Phone: 419-237-2501
Fax: 419-237-2671

❑ FCHC Primary Care Wauseon
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3242
Fax: 419-335-3222

❑ FCHC Orthopedics
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-2663
Fax: 419-335-9615

❑ FCHC OB/GYN
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-6377
Fax: 419-335-6807

❑ FCHC Pediatrics
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3333
Fax: 419-337-7845

❑ FCHC Behavioral Health
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-330-2790
Fax: 419-330-2774

❑ FCHC General Surgery
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-337-7478
Fax: 419-337-7846

❑ FCHC Urology
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-2000
Fax: 419-335-7500

❑ FCHC Urgent Care
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-337-7467
Fax: 419-337-7468

❑ FCHC Cardiology
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-330-2769
Fax: 419-330-2738

❑ FCHC Ear, Nose & Throat
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3712
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:_____