AULTMAN
ORRVILLE
DUNLAP
FAMILY PHYSICIANS

APPOINTMENT INFORMATION

DATE: _____ Time: _____

Location: _____

Dear New Patient:

We welcome you 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.

Thank you for becoming a new patient. Please have this new patient information packet filled out **COMPLETELY** prior to your appointment, you may return it to the office prior to your scheduled appointment or bring it to your appointment and arrive **30 minutes** prior to your scheduled appointment time to complete the registration process. You must bring your updated **Insurance Card, Photo ID,** and **co-payment.** 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

Aultman Orrville Dunlap Family Physicians does not provide controlled medication management and will not prescribe any controlled medications at your initial appointment. We will provide you with a referral to a specialist 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.

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 speaking with our receptionist.**

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.

No Show and Late Cancellation Policy

Any new patient who no-shows or does not cancel their appointment within 24 hours of their scheduled appointment time will be discharged from the practice and unable to reschedule with the practice.

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

Sincerely,
Dunlap Family Physicians

830 S Main St.
Orrville, Ohio 44667
Ph: 330-684-2015
Fax: 330-684-2075

129 N Wenger Rd
Dalton, Ohio 44618
Ph: 330-684-5480
Fax: 330-828-0094

49 Maple St
Apple Creek, Ohio 44606
Ph: 330-684-5470
Fax: 330-698-2045

400 Collier Dr. Suite C
Doylestown, Ohio 44230
Ph: 330-991-0038
Fax: 330-991-0138

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Authorization for Release of Health Information

Name	**DOB**	
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*
Address	*Address*
City, State, Zip Code	*City, State, Zip Code*
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 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 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)

Is your mother alive?	**□ Yes (Age: _____)**	**□ No (Age at death: _____)**	**Cause of death:**	
Is your father alive?	**□ Yes (Age: _____)**	**□ No (Age at death: _____)**	**Cause of death:**	

	Self	Is there a family history?	
Alcoholism		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Anemia		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Arthritis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Asthma		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Barium X-rays		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Bladder infections/stones		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Blood Clots		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Broken Bones (where:)		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Bronchitis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Cancer: Type:		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Addt'l Info for Cancer:			
Concussion		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Diabetes: Type:		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Drug Abuse		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Depression		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Epilepsy/Seizures		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Gallbladder disease		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Glaucoma		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Hair Loss		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Head Injury		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Heart catheterization		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Heart Disease		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Addt'l Info for Heart Disease:			
Hepatitis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
High Blood Pressure		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
High Cholesterol		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
HIV/Immune DX		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Kidney infections/stones		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Kidney disease		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Liver Disease		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Hepatitis	:	□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Lung Disease		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Mental illness		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Migraines		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Mononucleosis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Moodiness		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Osteoarthritis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Osteoporosis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Pain (location:)		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Phlebitis (inflammation of vein)		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Pneumonia		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Rheumatic Arthritis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Rheumatic Fever		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Seizures		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Sprains		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Stroke		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Suicide Attempt		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Thyroid Disease		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Tuberculosis		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Ulcer in GI Tract		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent

Venereal Disease		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Whiplash		□ Yes, please check who	□ Mother □ Father □ Brother □ Sister □ Maternal Grandparent □ Paternal Grandparent
Is there any medical history with your brothers, sisters, sons or daughters 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	?	GENITOURINARY	
			Burning on urination	
			Trouble starting urine flow	
			Trouble stopping urine flow	
			Loss of control of urine	
			Frequency of urination	
			Getting up at night to urinate	
			Blood in urine	
			Stones in kidney or bladder	
			Erectile dysfunction (ED)	
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 lumps	
			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	

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

DIABETIC PATIENTS ONLY			
Date of Last Retinal Eye Exam		Physician Name:	
Date of Last Foot Exam by Podiatrist		Podiatrist Name:	

Patient Signature: _____ Date: _____

Physician Review: _____ Date: _____