Welcome to
Decatur County Memorial Hospital
Physician Practices

Decatur County Memorial Hospital
The Quality Care You Want. Close By.

Important Information for New Patients of Family Medicine, Primary Care, and Tree City Medical:

For all new patients:

- Please arrive 30 minutes prior to your appointment time in order to allow sufficient time to complete necessary paperwork, enter your information into our system, and update your past medical history.
- Please bring ALL bottles for all medications and supplements that you are taking. This helps us make sure that our information is as accurate as possible.
- At your first appointment, your provider will review your past medical history and your current health status with you. The more information we have, the better care we can provide. Please be ready to provide a detailed medical history, including any previous surgeries, health issues, and family history.
- Please have the names and contact information for all previous medical care providers at your visit so that we can obtain records. It is best if you complete a Release of Information form (ROI) with these providers ahead of time, in order to have your records available at the time of your first visit.
- If your insurance requires a co-pay, we will be collecting that payment at the time of check-in for your first visit. Please be sure to bring an appropriate form of payment. We accept cash, check, and credit cards (except American Express).
- Please bring your identification and insurance card(s) to all visits so that we always have the most updated information.

For new patients who are currently on narcotic prescriptions (also known as controlled substances):

- Our providers WILL NOT be dispensing new narcotic prescriptions or refilling current narcotic prescriptions at the first visit. You will need to contact your previous provider for any refill needs.
- If your provider decides that narcotic prescriptions are medically indicated for treatment of your condition(s), then you may be asked to complete a controlled substance agreement outlining additional terms related to these prescriptions. Violation of this agreement may result in your dismissal from both Primary Care and Tree City Medical practices.

We look forward to caring for you and helping you stay in good health!

Decatur County Family Medicine
Physicians & Nurse Practitioners
902 N. Lincoln St., Greensburg
phone: 812-222-2229

Dr. Jamie Cooper
Dr. Brian Israel

Decatur County Primary Care
Physicians & Nurse Practitioners
718 N. Lincoln St., Greensburg
phone: 812-222-3627(DOCS)

Dr. Nicole Boersma
Dr. Anjum Fazlani
Dr. Mary Fogler
Dr. Jami Rayles
Dr. Cody Wagner
Tracy Ingram, CFNP
Megan Israel, FNP-C
Jennifer Jersan, FNP-C
Lindsay Jobe, FNP
Chuck Kuhfahl, FNP-C
Emily Verseman, FNP

Tree City Medical
Physicians & Nurse Practitioners
955 N. Michigan Ave., Greensburg
phone: 812-222-3627(DOCS)

Dr. Arthur Alunday
Dr. Mary McCullough
Dr. Noel Mungcal
Dr. Krystle Roberts
Dr. Isaiah Steffen
Dr. Amanda Williams
Kelly Miller, FNP-C
Jill Prickel, FNP-C
Natasha Struewing, NP
Cary Troutman, NP
Shelly Walsman, NP

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New Patient Demographic Form

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Legal Name: _____ **Preferred Name:** _____
LAST FIRST MI

Date of Birth: ____/____/____ **Age:** _____ **Legal Sex:** □ M □ F **Gender Identity:** _____

Social Security Number: _____ **Primary Language:** □ English □ Other: _____

Ethnicity (please select one)**:** □ Hispanic or Latino □ Not Hispanic or Latino

Race (please select the one category you feel best represents you)**:** □ American Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian or Pacific Islander □ White

Marital Status: □ Single □ Married □ Long-term Partnership, not married □ Separated □ Divorced □ Widowed

Contact Information

Address: _____

City: _____ State: _____ Zip: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

How would you prefer to be contacted during the day? □ Home □ Work □ Cell

Can we leave a detailed message on your voicemail or answering machine? □ Yes □ No

E-mail address: _____

We can use your e-mail address to sign you up for our patient portal, which allows you to view your lab results and clinical information online, and to message your provider. May we register you for the portal? □ Yes □ No

Insurance and Payment Information

Guarantor: □ Self □ Other (enter information below)

Name: _____

DOB: ____/____/____ SSN: _____

Guarantor Contact Information

Address: _____

City: _____ State: _____

Employer: _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

Primary Insurance Provider: _____

Group/Policy #:_____

Policy Holder's Information:

Name:_____ DOB: ____/____/____

Place of Employment: _____

Relationship to You: □ Self □ Spouse □ Parent □ Child

Secondary Insurance Provider:_____

Group/Policy #: _____

Policy Holder's Information:

Name:_____ DOB: ____/____/____

Place of Employment: _____

Relationship to You: □ Self □ Spouse □ Parent □ Child

With my signature, I certify that the above information is correct to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** ____/____/____

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New Patient Information Form

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Please complete as much as you are able. Having your full health history will help your provider to give you better care.

Legal Name: _____ **Preferred Name:** _____
LAST FIRST MI

Date of Birth: ____/____/____ **Age:** _____ **Legal Sex:** □ M □ F **Gender Identity:** _____

What is your main concern today? _____

Allergies you Have and Medications you are Taking

Allergies and Medication Reactions:
(please list reactions to medications if you know them)

_____

_____

_____

_____

_____

Medicines (including dose and how often they are taken):
(please include over-the-counter meds, vitamins, herbs and supplements)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Your Medical History

*Please mark all conditions that **you** have or had in the past.*

Now	Past		Now	Past	
☐	☐	Acid Reflux/GERD	☐	☐	High Cholesterol
☐	☐	ADHD	☐	☐	HIV
☐	☐	Alcohol/Substance Abuse	☐	☐	Irritable Bowel Syndrome
☐	☐	Anemia	☐	☐	Lupus
☐	☐	Anxiety	☐	☐	Liver Disease
☐	☐	Arthritis	☐	☐	Kidney Disease
☐	☐	Asthma	☐	☐	Kidney Stones
☐	☐	Autoimmune Issues	☐	☐	Macular Degeneration
☐	☐	Back Pain/Disc Disease	☐	☐	Menopause
☐	☐	Bipolar Disorder	☐	☐	Miscarriage (number: _____)
☐	☐	Bladder Problems	☐	☐	Abortion (number: _____)
☐	☐	Bleeding Problems	☐	☐	Neuropathy/Nerve Pain
☐	☐	Breast Problems	☐	☐	Osteoporosis/Osteopenia
☐	☐	Cancer (type: _____)	☐	☐	Parkinson's Disease
☐	☐	Cataracts	☐	☐	Peripheral Vascular Disease
☐	☐	Congestive Heart Failure	☐	☐	Pregnancy (number: _____)
☐	☐	COPD/Emphysema	☐	☐	Prostate Problems
☐	☐	Coronary Artery Disease	☐	☐	Psoriasis
☐	☐	Crohn's Disease	☐	☐	Pulmonary Embolism
☐	☐	Dementia	☐	☐	Rheumatoid Arthritis
☐	☐	Depression	☐	☐	Seizures
☐	☐	Diabetes (on insulin? □ Yes □ No)	☐	☐	Sleep Apnea
☐	☐	Diverticulitis	☐	☐	Skin Ulcers
☐	☐	DVT/Blood Clot	☐	☐	Stroke
☐	☐	Erectile Dysfunction	☐	☐	Stomach Ulcers
☐	☐	Glaucoma	☐	☐	Thyroid Problems
☐	☐	Heart Attacks/MI	☐	☐	Tuberculosis
☐	☐	Hepatitis	☐	☐	Ulcerative Colitis
☐	☐	High Blood Pressure	☐	☐	Urinary Incontinence

Medical Conditions you have that are not listed above:

_____

_____

_____

Your Surgical History

Please list all surgeries that you have had and include approximate dates, if known

_____

_____

_____

_____

_____

_____

Your Family History

Please be as complete as you can.

	Age	Still Living?	Cause of Death	Medical or Psychiatric Conditions
Father				
Mother				
Brothers/Sisters				
Grandparents				

Any family history of birth defects or genetic diseases? Please be as specific as you can.

_____

_____

_____

Other Family Members not listed with Significant Medical Issues:

_____

_____

_____

_____

Your Social History:

Do you currently smoke or use other tobacco products? □ Yes □ No, but I have in the past □ No, never

What do you use? □ Cigarettes □ Pipe □ Cigars □ e-cigarettes □ Chewing tobacco □ Other: _____

When did you start using tobacco? _____ How much did/do you use? _____

If you have quit smoking, when? _____ If not, have you considered quitting? □ Yes □ No

Do you currently drink alcohol? □ Yes □ No, but I have in the past □ No, never

How much alcohol do you drink? □ Daily, 0-2 drinks per day □ Daily, more than 2 drinks per day □ A few times a week □ A few times a month □ Holidays and special occasions only □ Other: _____

Do you use marijuana or other drugs, including medications prescribed for someone else?

□ Yes □ No, but I have in the past □ No, never □ Prefer not to respond

What have you used? □ Marijuana □ Cocaine/crack □ Heroin □ Amphetamines □ Tranquilizers □ Sedatives □ Painkillers □ Club or Designer Drugs □ Inhalants □ IV drugs □ Methamphetamine □ Prescription Medications □ Unknown/Not Sure □ Other: _____

Other Healthcare Providers:

When did you last see a doctor? _____ What was that visit for? _____

Do you see any specialists or other healthcare providers (cardiologist, mental health provider, kidney doctor, dentist, chiropractor, etc)? If so, please provide names and locations so we can coordinate your care with them.

_____

_____

_____

Preventive Care:

Last Bone Density Scan: _____ □ Normal □ Abnormal Last Colonoscopy: _____ □ Normal □ Abnormal

When was your last tetanus shot (year)? _____ Pneumonia shot? _____ Flu shot? _____

Last menstrual period: _____ Are your periods regular? □ Yes (how often? _____) □ No

Last Pap Smear: _____ □ Normal □ Abnormal Last Mammogram: _____ □ Normal □ Abnormal

Have you had any blood work, x-rays, or other testing done in the last 6 months? □ Yes □ No

When and where was it done? _____

Are you sexually active? □ Yes, currently □ No, but I have been in the past □ No, I have never been

Preferred sexual partners? □ Only Men □ Mostly Men, Sometimes Women □ Both Men and Women □ Mostly Women, Sometimes Men □ Only Women

Are you or your partner(s) using birth control?

□ Yes, condoms □ Yes, another type (what type? _____)

□ No, and I/we are planning to conceive □ No, and I/we are not planning to conceive

Patient Signature: _____ **Date:** ____/____/____