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 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 Primary Care
Physicians & Nurse Practitioners
718 N Lincoln St, Greensburg
phone: 812-662-0588

Dr. Nicole Boersma
Dr. Purnendu Datta
Dr. Anjum Fazlani
Dr. Jami Rayles
Dr. Andy Tran
Dr. Cody Wagner
Tracy Ingram, NP
Rebecca Lovins, NP
Emily McNulty, NP

Tree City Medical
Physicians & Nurse Practitioners
955 N Michigan Ave, Greensburg
phone: 812-663-7277

Dr. Arthur Alunday
Dr. Jennifer Fletcher
Dr. Mary McCullough
Dr. Noel Mungcal
Suzi Johannigman, NP
Natasha Struewing, NP
Cary Troutman, NP
Shelly Walsman, NP

Decatur County Memorial Hospital
Physician Practices

New Patient Demographic Form

Decatur County Memorial Hospital
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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:** ____/____/____

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PHYSICIAN OFFICES

HIPAA DISCLOSURES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any future care treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing competencies of healthcare professionals.

I understand and have been offered a copy of Notice of Privacy Practices that provides more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this Organization reserves the right to change their notice and practices and I may request a copy of the revision by contacting the Health Information Department of the organization.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. Request for revocation should be directed to the HIM Department or Privacy Officer.

_____ I give Decatur County Memorial Hospital Physician Offices permission to discuss and all aspects of my medical care with:

_____

(names of those who we may discuss test results or any other health information on you)

_____ I give permission for Decatur County Memorial Hospital Physician Offices to notify them any time I have an appointment.

_____ I give the staff of Decatur County Memorial Hospital Physician Offices permission to leave protected health information about me on my answering machine/voicemail.

_____ I understand that I may revoke this at any time by submitting my wishes in writing to Decatur County Memorial Hospital Physician Offices.

CONSENT TO TREAT: I request and give consent to my healthcare provider to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my healthcare provider for my health and well- being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL_____

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize my healthcare provider to release information from my medical record to my insurance carrier(s), or governmental agency for processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my healthcare provider, on my behalf.

INITIAL_____

MEDICARE CERTIFICATION: I certify the information given by me in applying payment under Title XVIII of the Social Security Act is correct. I authorize my healthcare provider who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my healthcare provider treating me, on my behalf. INITIAL_____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My healthcare provider will assist patients in obtaining insurance benefits when those benefits are assigned to my healthcare provider. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my healthcare provider. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. Patient agrees to pay the Patient Balance Due on each Monthly Statement, in full within 15 days of that statement.

INITIAL_____

ADVANCE DIRECTIVE

Do You Have A Living Will? YES_____ NO_____
If YES a copy is needed for your chart.
A Copy Was Received By This Office. Date_____

Have You Appointed A Healthcare Representative? YES_____ NO_____
If YES a copy is needed for your chart.
A Copy Was Received By This Office. Date_____

Have You Given Anyone Your Power Of Attorney? YES_____ NO_____
If YES a copy is needed for your chart.
A Copy Was Received By This Office. Date_____

_____ _____ _____
Signature of Patient or Legal Representative Witness Date

_____ _____
Relationship to Patient Reason Patient Unable to Sign

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(812) 663-1250 | www.dcmh.net

3 Reasons to have your prescriptions filled at the DCMH Pharmacy:

1. QUALITY

As a DCMH patient, our Pharmacists have greater access to your medical information enabling them to provide a higher level of clinical care unique to your needs.

2. SERVICE & CONVENIENCE

DCMH Pharmacy is open Monday-Friday from 8 a.m. to 8 p.m. and Saturdays from 8 a.m to 2 p.m and offers fast, friendly customer service, a convenient drive-thru, **free home delivery** and competitive pricing.

3. COMMUNITY

DCMH is a **not-for-profit** county organization that reinvests 100% of its earnings into better serving the residents of Decatur County.

If you do not already have your prescriptions filled at the DCMH Pharmacy and would like for them to be, please fill in the form below for each family member whose prescriptions you would like for us to transfer. Thank you.

PRESCRIPTION TRANSFER REQUEST FORM

Name:	Name:	Name:	Name:
DOB:	DOB:	DOB:	DOB:
Name:	Name:	Name:	Name:
DOB:	DOB:	DOB:	DOB:

Address: _____

_____

Home Number: _____

Cell Number: _____

Current Pharmacy Name: _____

Current Pharmacy Location: _____

Allergies to Medications: _____

_____

_____

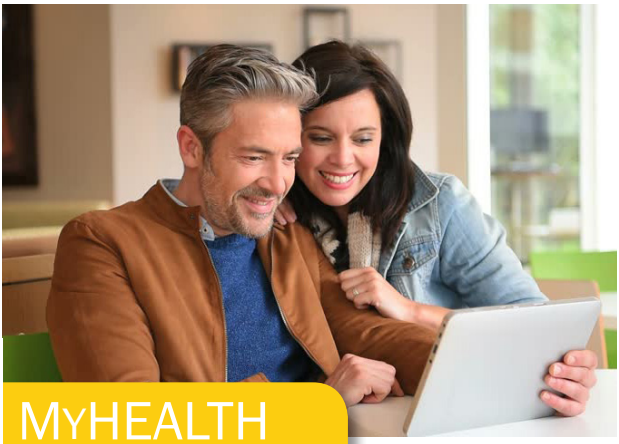
Please give form to Receptionist or you may mail it to: DCMH Pharmacy, 720 N. Lincoln Street, Greensburg, IN 47240
If possible, please supply a copy of your Pharmacy insurance card as well.

FOR OFFICE USE ONLY:

☐ Prescriptions transferred

By _____

Date _____



MyHEALTH
PATIENT PORTAL

MyHealth is Decatur County Memorial Hospital and its affiliated medical practices patient portal. The patient portal is a secure online web product that gives you 24-hour access to your personal health information.

Patients can view and print health information such as:

- History of hospitalizations and clinic visits
- Provider listing per specialty
- Lab and Radiology test results
- Discharge instructions
- Medical conditions/medication history/allergies/ health summary
- View scheduled appointments

Patients can also interact with providers through the secure electronic exchange of messages similar to email.

To register, go to **www.dcmh.net** and click on the MyHealth Patient Portal or Contact Susie Cupp at **812-663-1226** with any questions.

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720 N. Lincoln Street | Greensburg, Indiana

Patient Portal Proxy Form

If you would like to register your minor children or become a proxy for another adult, you must complete the "Authorization for Proxy Access to myHealth Patient Portal." The proxy would then be able to easily view their loved ones' records by toggling under their own username to their loved ones' name without creating more usernames and passwords. The form is located at dcmh.net/myhealth and must be sent via interdisciplinary mail or scanned and emailed to Susie Cupp at susie.cupp@dcmh.net in Nursing Administration.

Patient Portal App

We now have an app available for patients to access the MyHealth patient portal! Once you have completed the registration process, you can use your username and password at the DCMH website, MyHealth Patient Portal page or use the QR codes below to access your medical records TODAY. It's that easy!