

# 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: 812-222-3627(DOCS)

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

#### **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. Amanda Williams  
Suzi Johannigman, NP  
Natasha Struewing, NP  
Cary Troutman, NP  
Sam Walke, NP  
Shelly Walsman, NP

Decatur County Memorial Hospital  
Physician Practices



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### New Patient Demographic Form

Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: LAST \_\_\_/\_\_\_/\_\_\_ FIRST Age: \_\_\_\_\_ MI 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: \_\_\_/\_\_\_/\_\_\_



## Your Medical History

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

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

**Medical Conditions you have that are not listed above:**

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DCMH New Patient Information Form for (your name): \_\_\_\_\_

**CLN-060-X, p. 4 of 6**

Approved: 10/31/2019

Reviewed: 10/31/2019

### Your Surgical History

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

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### Your Family History

Please be as complete as you can.

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

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

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Other Family Members not listed with Significant Medical Issues:

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DCMH New Patient Information Form for (your name): \_\_\_\_\_

## 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.

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## 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

DCMH New Patient Information Form for (your name): \_\_\_\_\_