Morrow County Hospital
OhioHealth

MCH Primary Care

- ☐ Baker Street (419) 947.8001
- ☐ Cardinal Center (419) 253.0585
- ☐ Cardington (419) 864.4440
- ☐ Mt. Gilead (419) 947.3015
- ☐ Northfield (419) 362.6033

PATIENT INFORMATION

Personal Information (Please Print)

Full Name: _____
(Last) (First) (Middle)
Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (____)_____ Business Phone: (____)_____ Cell Phone: (____)_____

Where would you prefer to be contacted for medical information or test results? (Please check all that apply)

Home: Yes _____ No _____ Cell: Yes _____ No_____ Patient Portal: Yes _____ No _____

E-mail Address: _____

Social Security #: _____ Sex: Male / Female Marital Status: _____

Age: _____ Date of Birth: _____ Place of Birth (city, state ,country, region) _____

Race or Nationality: _____ Religion: _____

Preferred Language: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Primary Phone #: (_____)_____ Secondary Phone #: (____)_____

Authorized Individuals

Are we permitted to give lab, diagnostic, and/or any other test results or appointment information to family members? (Please Check) Yes_____ No_____

Please provide name(s) of individuals with contact information and relationship to you for individuals we may talk to in reference of your medical information:

Name: _____ Relationship: _____ Phone: (____)_____
Name: _____ Relationship: _____ Phone: (____)_____
Name: _____ Relationship: _____ Phone: (____)_____

MORROW COUNTY HOSPITAL
PRIMARY CARE
PATIENT INFORMATION

Durable Power of Attorney / Living Will

Living Will	☐ Yes ☐ No	☐ I have provided the hospital with a copy
Durable Power of Attorney for Health Care	☐ Yes ☐ No	☐ I have provided the hospital with a copy
DNR	☐ Yes ☐ No	☐ I have provided the hospital with a copy

I would like further information for: ☐ Living Will ☐ Durable Power of Attorney for Health Care ☐ DNR

INSURANCE AND PAYMENT INFORMATION **(insurance card required on arrival to your appointment)**

Primary Insurance:	**Secondary Insurance:**
Name of Policy Holder: _____	Name of Policy Holder:_____
Insurance Name: _____	Insurance Name:_____
Identification #: _____	Identification #:_____
Group #: _____	Group #:_____
Employer: _____	Employer:_____
Policy Holder Date of Birth: _____	Policy Holder Date of Birth:_____
Social Security of Policy Holder: _____	Social Security of Policy Holder:_____

ASSIGNMENT AND RELEASE

Responsible party if different than patient or insurance information provided:

Name: _____

Address: _____

Relationship to patient: _____ Phone #: (_____)_____

I, the undersigned, certify that I (or my dependents) have insurance coverage as described above and assign directly to Morrow County Hospital all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Morrow County Hospital to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party: _____ Date: _____

MORROW COUNTY HOSPITAL
PRIMARY CARE
HEALTH QUESTIONNAIRE

To be completed by the patient – Please Print

Name _____ **Date of Birth** _____

Preferred Pharmacy ☐ Local ☐ Mail

Pharmacy Name _____ **Phone Number** _____

Drug Allergies _____

Describe briefly the reason for your visit today:

_____

_____

_____

_____

_____

Hospitalizations (If you have been in the hospital overnight – state the year – illness/operation) (Do not include normal pregnancies)

Year	Illness/Operation	Year	Illness/Operation

Past Medical History Have you ever had the following (check yes or no, or leave blank if uncertain)

AIDS or HIV+	☐Yes ☐ No	Glaucoma	☐Yes ☐ No	Pneumonia	☐Yes ☐ No
Anemia	☐Yes ☐ No	Heart disease	☐Yes ☐ No	Polio	☐Yes ☐ No
Arthritis	☐Yes ☐ No	Hemorrhoids	☐Yes ☐ No	Rheumatic fever	☐Yes ☐ No
Asthma	☐Yes ☐ No	Hepatitis	☐Yes ☐ No	Scarlet fever	☐Yes ☐ No
Back trouble	☐Yes ☐ No	Hernia	☐Yes ☐ No	Smallpox	☐Yes ☐ No
Bladder infections	☐Yes ☐ No	High/low BP	☐Yes ☐ No	Stroke	☐Yes ☐ No
Bleeding tendency	☐Yes ☐ No	Hives/eczema	☐Yes ☐ No	Thyroid disease	☐Yes ☐ No
Bronchitis	☐Yes ☐ No	Infectious mono	☐Yes ☐ No	Transfusions	☐Yes ☐ No
Cancer	☐Yes ☐ No	Kidney disease	☐Yes ☐ No	Tuberculosis	☐Yes ☐ No
Chickenpox	☐Yes ☐ No	Measles	☐Yes ☐ No	Ulcer	☐Yes ☐ No
Diabetes	☐Yes ☐ No	Migraines	☐Yes ☐ No	Venereal disease	☐Yes ☐ No
Diphtheria	☐Yes ☐ No	Mitral valve	☐Yes ☐ No	Whooping cough	☐Yes ☐ No
Epilepsy	☐Yes ☐ No	Mumps	☐Yes ☐ No	Any other disease (Please list below)	☐Yes ☐ No

_____

_____

_____

MORROW COUNTY HOSPITAL
PRIMARY CARE
HEALTH QUESTIONNAIRE

Family History
Has any blood relative had any of the following: (Please check yes or no and leave black if uncertain) What family member, ie; father, mother.

Allergies	Yes☐ No☐	_____	Epilepsy	Yes☐ No☐	_____
Anemia	Yes☐ No☐	_____	Heart disease	Yes☐ No☐	_____
Bleeding tendency	Yes☐ No☐	_____	High blood pressure	Yes☐ No☐	_____
Cancer	Yes☐ No☐	_____	Stroke	Yes☐ No☐	_____
Diabetes	Yes☐ No☐	_____	Tuberculosis	Yes☐ No☐	_____

Medication	**Dosage**	**Times Per Day**

Social History

Tobacco	Yes☐ No☐	Packs per day _____ for _____ years
Alcohol	Yes☐ No☐	Drinks per week _____
Caffeine	Yes☐ No☐	Cups per day _____
Illegal drugs	Yes☐ No☐	Type _____

The last time you had a (list year)

Flu vaccine _____	Tetanus shot _____
Hepatitis vaccine _____	TB test _____
Pneumonia shot _____	Rubella vaccine _____
Blood stool test _____	Rectal exam _____
Sigmoid exam _____	Eye exam _____
Cholesterol test _____	PSA _____

For Women Only
Age at onset of menstrual period _____
Date of last menstrual period _____
Use birth control ☐ Yes ☐ No Type: _____
Number of pregnancies _____ Number of live births _____
Number of abortions _____ Number of miscarriages _____

Year of last
Breast exam _____ Results _____
Mammogram _____ Results _____
PAP smear _____ Results _____

Patient signature: _____ Date: _____