Welcome to
Decatur County Memorial Hospital
Ambulatory Physician Practices

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

Important Information for New Patients of Physician Practices:

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 your medical 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 medically indicated, your provider may provide narcotic prescriptions for treatment of your condition(s), and then ask you to complete a controlled substance agreement outlining additional terms related to these prescriptions. Violation of this agreement may result in your dismissal from DCMH medical practices.

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

To reach any of our offices, please call 812-222-3627(DOCS).

Ambulatory Physician Practices
Decatur County Primary Care
718 N Lincoln St, Greensburg

Ambulatory Physician Practices
Tree City Medical Partners
955 N Michigan Ave, Greensburg

Ambulatory Physician Practices
Decatur County Family Medicine
901 N. Lincoln Street, Greensburg
Suite 2

Ambulatory Physician Practices
Westport Clinic
308 E Mulberry St, Westport

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:** _____ **Gender you were biologically born as**: □ 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 or Caucasian

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:** ____/____/____

Decatur County Memorial Hospital
Physician Practices

New Patient Information Form

Decatur County Memorial Hospital
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Please complete as much as possible. 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:** _____ **Gender you were biologically born as**: □ M □ F

Gender Identity: _____

What is your main concern today? _____

Allergies and Medication Reactions:

(please list reactions to medications and allergies if you know them)

_____

_____

_____

_____

_____

Medications:

(please list current medications you are taking)

Medications	Dose (e.g. mg/pill)	How many times per day?

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

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back Surgery (lumbar)			
Biopsy (location in comments)			Circle: Right Left Both
Breast Biopsy			Circle: Right Left Both
Breast Surgery			
Cataract Surgery			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
C-Section			
Echocardiogram (heart)			
EGD (Stomach Endoscopy)			
Gallbladder removal			Circle: Laparoscopic
Hip Surgery			Circle: Right Left Both
Hysterectomy (Partial, Ovaries Left)			Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (total, incl ovaries)			Circle: Laparoscopic Vaginal Abdominal
Knee Surgery			Circle: Right Left Both
LEEP (Cervix surgery)			
Neck (spine) surgery			
Ovary removal			Circle: Right Left Both
Pulmonary Function test			
Sigmoidoscopy			
Sinus Surgery			
Stress Test (Stress Echo)			
Stress Test (thallium/ Perfusion)			
Stress Test (treadmill)			
Tonsillectomy			
Tubal Ligation			
Vasectomy			
Other (list)			

☐ **Please check box if you have never had any medical procedures or surgeries, please go to next page.**

Your Family History

Please complete as much as you can.

Are you adopted? ☐ Yes, ☐ No If adopted and you do NOT know your family history skip the Family History section and continue to Health Issues.

Diseases & Conditions	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's dad	Dad's mom	Other Blood relatives (list relationship to you)	List age(s) at diagnosis and if it was the cause of death; if known
No significant history known										
Hypertension- High blood pressure										
Hyperlipidemia- High Cholesterol										
Heart Attack (coronary Artery Disease)										
Diabetes Type II (adult onset)										
Cancer, Breast										
Cancer, Colon										
Cancer, Prostate										
Osteoporosis										
Depression										
Alcoholism/ Drug Abuse										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Lung										
Cancer, Ovarian										
Cancer, other type										
Colon Polyp										
Diabetes Type I (childhood onset)										
Emphysema (COPD)										
Genetic Disorder										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (other)										
Hepatitis B or C										
Hip Fracture										
Hypothyroidism/ Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Stroke										
Sudden Cardiac Death										
Other										

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: _____

Are you exposed to second hand smoke: □ Yes □ No

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

Last tetanus vaccine: _____ Last pneumonia vaccine: _____ Last flu vaccine: _____

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

Sexual partner preference? □ 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, other (what type? _____)

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

Gynecological Health History:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Number of abortions: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause/hysterectomy): _____ □ not applicable

Do you have concerns about your periods or menopause you would like to discuss? □ Yes □ No

If you are having periods, how often do they occur? Every _____days. How long do they last? _____days

Socioeconomic:

Name you prefer we use to contact you (nickname, first, last, Mr. Mrs., Ms. etc.) _____

County of birth: _____

Who lives at home with you: □ No one □ Spouse/Partner □ Children □ Pets (what type) _____

□ other _____

Spouse/Partners name: _____

Occupation (or Prior Occupation): _____Employer: _____

If you are not working, are you: □ Retired □ Unemployed □ On a leave of absence □ Disabled □ Homemaker

Number of Children: _____ Ages (if minors) _____# of Grandchildren_____

Education: □ Did not graduate High School □ High School or GED □ Trade School □ College □ Graduate School

□ Other _____

Medical Forms:

Please check any of the following documents you have completed:

□ Advanced Directive or Health Care Representative

□ Durable Power of Attorney for healthcare decisions

□ Living Will

□ POLST (Physician Orders for Life Sustaining Therapy)

□ I am aware of options/have the forms but have not completed them

□ I am not familiar with these options and would like more information

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