JOHNSON MEMORIAL HEALTH

Internal Medicine and Pulmonology
1155 W. Jefferson Street
Suite 101, 202
Franklin, IN 46131
Phone 317-346-3883

Fax 317-346-3141

Our goal is to ensure that your experience at Johnson Memorial Health is exceptional. To ensure the highest quality service and care to our patients, we have policies and procedures we ask you to observe. If you have any questions or concerns please contact our office.

Patient information: a patient registration and medical history form is enclosed, please complete them prior to your upcoming visit and bring them with you to your appointment.

Insurance cards: please bring a copy of your insurance card with you to every appointment. Without it there is no way to submit to your insurance and it will be assumed you are self-pay.

Photo ID: In order to protect your identity, please bring a Photo ID with you to every visit. If you cannot provide this, we may need to reschedule your appointment.

Late arrival: Please be prompt when arriving for your appointment; we ask that you arrive 15 minutes early so we do not take away from your time with the provider.

No show: If you are unable to keep your appointment, please give 24 hour notice. If there are excessive no shows be advised that is grounds for dismissal from the practice.

Co-Pay: Your co-pay is required at the time of service per your insurance provider.

Medical Records: Upon written request and signature, a copy of your medical records will be released to you. This process can take 7-10 business days. The state of Indiana has imposed a predefined fee schedule for copying medical records that will be charged accordingly to the patient.

We look forward to meeting you and establishing a relationship to meet your healthcare needs!

Gaston Dana, DO, Susan Murphy, MD, Isam Habib, MD, Michael Young, MD
Christopher Zietlow, MD, Maggie Doty-Lewis, PA-C, Grant Walker, PA-C

NEW PATIENT INFORMATION / Medical History

Name: _____ DOB: _____

Please list what you would like to discuss today at your appointment:

1) _____

2) _____

PHARMACY:

Local: _____ Mail Order: _____

Phone Number(s): _____

ALLERGIES:

Allergies to medications with REACTION/S: _____

_____

Allergies to food / environment / other with REACTION/S:

_____

_____

MEDICATION LIST:

List ALL medications you take, including over-the-counter (OTC) medications and vitamins. Include name of medication, strength, and dosage.

Name	**Strength**	**Dose**

Name:_____ **DOB:** _____

Personal Medical History: Please circle all that apply

ADHD	COPD/Emphysema	Kidney Disease	Rheumatoid Arthritis
Alcoholism	Dementia	High Cholesterol	Seizures
Allergies, Seasonal	Depression	HIV	Sleep Apnea
Anemia	Diabetes 1 or 2	Hepatitis	Stroke
Anxiety	Diverticulitis	Irritable Bowel Syndrome	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (blood clot)	Lupus	Ulcerative Colitis
Arthritis	GERD (acid reflux)	Liver Disease	
Asthma	Glaucoma	Macular Degeneration	
Bipolar	Heart Disease	Neuropathy	
Bladder Problems/ Incontinence	Heart Attack	Osteopenia/Osteoporosis	
Bleeding Problems	Hiatal hernia	Parkinson's disease	
Cancer:_____	High Blood pressure	Peripheral Vascular Disease	
Crohns Disease	Kidney Stones	Pulmonary Embolism (PE)	

Surgical History: Please list all prior surgeries and approximate dates performed.

Name of Surgery Date

_____

_____

_____

_____

_____

Name: _____ Date: _____

Social History:

Smoking/tobacco use: Never____ Current ____ Past ____ Type:_____
Amount per Day: _____ # of Years: _____

Alcohol: Current _____ Past_____ Never _____ Drinks/week: _____

Substance Abuse: Current _____ Past _____ Never _____ Type: _____

Occupation: _____

Home/Environment:
Where do you currently reside (home/apartment/residential facility): _____
Who lives with you (significant other, spouse, child/grandchild)? _____
Any pets: _____

Diet: Regular ___, Restricted ___, Diabetic ___, Renal ___, Vegetarian ___, Other _____
Do you drink: Coffee ____ Soda ___ Tea ____ How much per day? _____

Exercise: Duration _____ Times per week _____ Type of exercise: _____

Sleep Pattern: Changes _____ No changes _____ How many hours do you sleep each night? _____

Sexual History:
Are you currently sexually active? _____ Number of partners: _____
Number of lifetime partners: _____ History of sexually transmitted illness: _____

General Social/Cultural History:
Education level: ___ Elementary ___ High School ___ Vocational ___ College ___ Graduate/Professional
Are there any vision problems that affect our communication? Yes/No
Are there any hearing problems that affect your communication? Yes/No
Are there any limitations to understanding or following instructions (written or verbal)? Yes/No
Are there any cultural or religious concerns you have related to our delivery of care? Yes/No
Are there any financial issues that directly impact our ability to manage your health? Yes/No

Advanced Directives:
___ None ___ DNR ___ Durable Power of Attorney ___ Living Will ___ HC Proxy

Name: _____ Date: _____

Family History:

Diagnosis	Mother	Father	Sibling	Grandmother Maternal	Grandfather Maternal	Grandmother Paternal	Grandfather Paternal
Asthma							
Cancer							
Depression							
Diabetes							
Heart Disease							
High Cholesterol							
Hypertension							
Mental Illness							
Thyroid Disorder							
Stroke							
Other							

Health Maintenance:

	Date	**Result**	**Where was completed**
Breast Exam			
Cardiac Stress Test			
Colonoscopy			
Dexa Scan			
Echocardiogram			
EKG			
Eye Exam			
IFOB (stool card)			
Foot Exam			
GYN Exam			

Outside Providers:

Name	Specialty	Phone Number

Patient Registration Form

Patient Information		Guarantor Information	
Patient Name		Guarantor Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Date of Birth		Date of Birth	
Sex		Sex	
Social Security #		Social Security #	
Email Address		Email Address	
Home Number		Home Number	
Mobile Number		Mobile Number	
Work Number		Work Number	

Emergecy Contact Related Person			
Name	Relationship	Home Phone	Mobile Phone

Primary Insurance		**Primary Subscriber Information**	
Payer Name		Name	
Health Plan Name		Relationship	
Contact Number		Address	
Group Number		City, State, Zip	
Member Number		Date of Birth	
Name on Card		Home Number	
Start Date		Mobile Number	
		Employer	

Secondary Insurance		**Secondary Subscriber Information**	
Payer Name		Name	
Health Plan Name		Relationship	
Contact Number		Address	
Group Number		City, State, Zip	
Member Number		Date of Birth	
Name on Card		Home Number	
Start Date		Mobile Number	
		Employer	

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to this provider for all covered medical services and supplies provided to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Authorization to Release Information

I authorize the release of any medical or any other information to the Center of Medicare and Medicaid (CMS), my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by this provider. A copy of this authorization will be sent to CMS, my insurance carrier(s), or other medical entity, if requested. This authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient or Legal Guardian	Date
Print Name of Patient or Legal Guardian	

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Patient Name_____

Date of Birth_____

Depression Screening - PHQ 9

Instructions: Over the past 2 weeks, how often have you been bothered by any of the following problems?

Please circle your answer.	**Not at all**	**Several days**	**More than half**	**Nearly every day**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
noticed- or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

For office use only: Add columns				
	Total Score_____			

If you checked off any problems, how difficult have theses problems made it for you to do your work, take care of things at home, or get along with other people? (circle)	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

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Date of Birth_____

Fall Risk Assessment Screening (STEADI)

Please circle Y or N to each question.	**YES**	**NO**
Have you fallen in the past 12 months?	**Y**	**N**
If you have fallen, have you fallen two or more times?	**Y**	**N**
If you have fallen, were you injured?	**Y**	**N**
Do you feel unsteady when you walk or stand?	**Y**	**N**
Do you worry about falling?	**Y**	**N**
For office use only: Add columns		
	Total Score_____	

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Functional Assessment Screening

Please check the appropriate answer for each question below.	**No** Independent - able to do without help	**Yes** Can do with some help from others	**Yes** Dependent - unable to do
Do you need help bathing?			
Do you need help dressing?			
Do you need help going to the restroom?			
Do you need help moving from the bed or a chair?			
Do you need any assistance with incontinence?			
Do you need help with eating or drinking?			

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Home Safety Screening

Please circle Y or N to the questions below:	YES	NO
Are emergency numbers kept by the phone and regularly updated?	Y	N
Are all household members aware of the dangers of smoking, especially in bed?	Y	N
Are working smoke alarm(s) and fire extinguisher(s) available for use?	Y	N
Are firearms stored unloaded and securely locked?	Y	N
Have throw rugs been removed or fastened down?	Y	N
Are non-slip mats in all bathrooms and shower?	Y	N
Do all stairways have a railing or banister?	Y	N
Are sidewalks and all outdoor steps clear of tools, toys, and other objects?	Y	N
Are doorways, halls, and stairs free of clutter?	Y	N
Are all electrical cords in working order, easily seen, and not run under rugs/carpet or wrapped around nails?	Y	N