Welcome to

FCHC Medical Group

FCHC Primary Care Delta

Providers

Ann M. Steck, MD
Elizabeth A. Barga, DO
Hayley L. Baldwin, NP-C
Paul T. Diaz, NP

Address

6696 US Highway 20A
Delta, OH 43515

Office Phone

(419) 822-3242

Use this number to schedule appointments, answer your general questions and connect you with team members.

Office Fax

(419) 330-2641

Office Hours

Monday-Friday
7:45 am – 5:00 pm

On Call Service Phone

(844) 694-1264

Use this number after hours and on weekends to talk to the On Call provider when the office is closed.

Website

fchcprimarycaredelta.org

Welcome!

Thank you for choosing us to be part of your healthcare team. We look forward to working with you to make sure you receive the care you need and keep you healthy and happy. We hope that the information provided on this guide will answer many of the questions you may have about our practice.

Appointments

If you have an emergency illness or symptom that requires immediate, urgent attention, call 911. If you need an appointment for illness, symptom, check-up, follow-up visit or annual visit call the office.

Please arrive 15 minutes prior to your appointment time. Patients who are more than 10 minutes late may be required to reschedule their appointments. Patients with 3 no-show appointments may result in dismissal from practice. Patients under the age of 18 must be accompanied by a parent or legal guardian at all appointments unless authorization for another adult to bring minor patient has been completed.

Appointment Check List

- Your insurance card.
- Current prescription bottles and non-prescription medications, vitamins and supplements bottles.
- A good description of the problem, how long you have had it and how it affects you.
- A list of questions you would like to discuss with your provider.
- A list of other health care providers you have visited.

Payment Options

We participate in most insurance plans, including Medicare. Be sure to check with your insurance to see if we are an in network provider. Please note that it is your responsibility to ensure that we are a covered provider.

Please be prepared to pay your co-pay and/or patient balance at the time of service. We accept cash, checks, Visa, MasterCard and Discover credit cards.

We are happy to answer questions, discuss payments or your bill anytime by calling (419) 330-1550.

Prescriptions

For refills of prescriptions, please contact your pharmacy. Please allow 48 hours for us to refill your prescriptions. We will contact you only if there is a problem or we have a question about your prescription refill request.

Please remember that refills can only be given to patients who have been seen within the past six months. If you have not been seen for more than six months, you will need to schedule an appointment.

If you have questions about a new prescription or about discontinuing medication(s), please call and speak with your provider's nurse.

After-Hours Care

If you would like to speak to the clinician on call to help you decide how to treat an illness after hours or to help you decide whether to go to the emergency room, call the On Call Service. If you receive care at an emergency room or urgent care center, please let us know by calling the office within 48 hours so we can assist with follow-up care as needed.

FCHC Medical Group

Pediatric Patient Registration Form

Last Name_____ First Name_____ MI_____ Date of Birth_____

Birth Sex ❑ Male ❑ Female SS#_____-_____-_____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Parent/Guardian _____ Phone (_____)_____ Text Reminders ❑ Yes ❑ No

Parent/Guardian _____ Phone (_____)_____ Home Phone (_____)_____

Appointment Reminders – Check One ❑ Call Mom ❑ Call Dad ❑ Text Mom ❑ Text Dad ❑ Call Home Phone

Primary Language ❑ English ❑ Spanish ❑ ASL ❑ Other _____ Interpreter Needed ❑ Yes ❑ No Marital Status_____

Primary Care Physician_____ Pharmacy/City_____

Race:	❑ American Indian/Alaska Native	❑ Asian	❑ Black/African American	
	❑ Native Hawaiian/Other Pacific Islander	❑ White	❑ Other	❑ Unknown
Ethnicity:	❑ Hispanic/Latino	❑ Not Hispanic/Latino		❑ Unknown

Guarantor – Person Financially Responsible

Last Name_____ First Name_____ MI_____ Date of Birth_____

Relationship to Patient_____ SS#_____-_____-_____

Address_____ City_____ State_____ Zip_____

Phone (_____)_____ ❑ Home ❑ Cell Employer_____

Insurance Information

❑ Self-Pay

Primary Insurance_____ Policy/ID# _____

❑ Same as Patient Information (If the patient is NOT the Subscriber please provide additional information)

Subscriber Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Date of Birth_____ SS#_____-_____-_____

Subscriber Employer_____ City_____

Secondary Insurance_____ Policy/ID# _____

❑ Same as Patient Information (If the patient is NOT the Subscriber please provide additional information)

Subscriber Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Date of Birth_____ SS#_____-_____-_____

Subscriber Employer_____ City_____

Authorization to Treat a Minor (Ages 0-18th Birthday):

If there are circumstances when I am unable to bring my child to the office for his/her appointment, I authorization for the following persons (over the age of 18) to obtain medical care for my child. I authorize the providers and staff of FCHC Medical Group to discuss my child's personal health information, appointment, insurance, test results and medical care to those listed below.

Name_____ Relationship_____ Phone (_____)_____

Name_____ Relationship_____ Phone (_____)_____

Name_____ Relationship_____ Phone (_____)_____

I attest that the above information is correct to the best of my knowledge.

_____ _____

Patient/Authorized Representative Signature Date

FCHC Medical Group

Pediatric Communication Release Form

Last Name_____ First Name_____ MI_____ Date of Birth_____

FCHC Medical Group strives to keep your Protected Health Information (PHI) and personal information secure. Requests, usage and disclosure of information is only granted to meet the intended need. You may change your Authorized Representatives at any time.

Authorized Representatives

I give permission for the following people to receive information as specified. Please mark all that apply.

Primary Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

Secondary Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

Additional Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

Additional Contact

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

_____ _____

Authorized Representative Signature Date

FCHC Medical Group

Pediatric Intake/Health History Form

Last Name_____ First Name_____ MI_____ Date of Birth_____

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER_____

MEDICINES/VITAMINS_____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Where was your child born (Hospital/City)? _____

Is the child yours by: Birth ❑ Adoption ❑ Stepchild ❑ Other ❑ _____

Please indicate any medical problems during pregnancy: None ❑ Specify: _____

Delivery by: Vaginal birth ❑ Caesarean ❑ If Caesarean, why? _____

Birth weight: _____ Birth length: _____

Please indicate any medical problems during the baby's newborn period:

None ❑ If premature, How early? _____ Other problems: _____

NUTRITION & FEEDING

Was/is your child breastfed? Yes ❑ No ❑ If yes, how long? _____

If your child is breastfed, are they on Vitamin D Supplement? Yes ❑ No ❑

Has your child had any feeding/dietary problems? Yes ❑ No ❑ If yes, specify:_____

Milk intake now: Type: Cow's Milk ❑ (Nonfat 1% fat 2% fat Whole milk) Soy Milk ❑ Rice Milk ❑ Other_____

Average ounces per day (Note 8 ounces = 1 cup) _____

SLEEP

Hours per night_____ Naps (number & length)_____

Any sleep problems?_____

DEVELOPMENT

At what age did your child: Sit Alone_____ Walk Alone_____ Say Words_____ Toilet Train (daytime)_____

Girls only: Age at first menstrual period_____

Any concerns about your child's behavior or development? Yes ❑ No ❑

DENTAL HISTORY

Has your child been seen by a dentist? Yes ❑ No ❑ Dentist_____

If so, how often? _____ Date of last visit_____ Water Source: City ❑ Well ❑ Other_____

SCHOOL HISTORY

Name of School _____ Grade_____

Any concerns about school performance? _____

Any concerns about relationship with: *Teachers* Yes ❑ No ❑ *Student* Yes ❑ No ❑

Pediatric Intake/Health History Form

Last Name_____ First Name_____ MI_____ Date of Birth_____

SAFETY

When your child is in the car, does he/she use: An infant seat ❑ Booster Seat ❑ Seatbelt ❑

Do you have smoke detectors in your home? Yes ❑ No ❑

Does your child wear a helmet for a Bike/Scooter or ATV? Yes ❑ No ❑

Do any members in the household smoke or use tobacco? Yes ❑ No ❑

Are there any guns in the home? Yes ❑ No ❑

Is there any violence in the home? Yes ❑ No ❑

IMMUNIZATIONS

Has your child had immunizations? Yes ❑ No ❑ Where? _____

Has your child had? Chickenpox ❑ Measles ❑ Mumps ❑ Rubella ❑ Meningitis ❑ Tuberculosis (TB)

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Name	Age	Relationship
_____			_____		
_____			_____		
_____			_____		

Are your child's parents: Married ❑ Unmarried ❑ Separated ❑ Divorced ❑

Child care: Parents ❑ Daycare ❑ Other_____

Concerns about your child: None ❑ Alcohol Use ❑ Drug Use ❑ Tobacco ❑ Sexual Activity ❑ Aggressive Behavior ❑

Are there any pets in the home? Yes ❑ No ❑ I so what pet? Dog(s) ❑ Cats(s) ❑ Other ❑

TV-hours per day _____ Computer hours per day _____ Video games hours per day _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates. _____

_____

Other Physicians or Specialists your Child sees (Names and specialty) _____

_____

Hospitalizations/operations (with dates) _____

Broken bones or severe sprains:_____

FAMILY HISTORY

Please check below if any immediate (parent, sibling, or grandparent) family members have any of the listed conditions:

Alcoholism ❑
Cancer ❑ Type_____
Depression/Suicide ❑
Diabetes ❑
Heart Attack ❑
High Blood Pressure ❑
High Cholesterol ❑
Stroke ❑
Other_____
Other_____

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Pediatric Review of Symptoms

Last Name_____ First Name_____ MI_____ Date of Birth_____

REVIEW OF SYMPTOMS: Please circle any current problems your child has on the list below:

Constitutional

Fever/chills/excessive sweating
Unexplained weight loss/gain

Eyes

Squinting/crossed eyes

Ears/Nose/Throat

Unusually load voice/hard of hearing
Mouth breathing/snoring
Bad Breath
Frequent runny nose
Problems with teeth/gums

Cardiovascular

Tires easily with exercise
Shortness of breath
Fainting

Respiratory

Cough/Wheeze
Chest Pain

Gastrointestinal

Nausea/vomiting/diarrhea
Constipation
Blood in Bowel Movement

Genitourinary

Bedwetting
Pain with urination
Discharge: penis or vagina

Musculoskeletal

Muscle/joint pain

Skin

Rashes
Unusual moles

Neurological

Headaches
Weakness
Clumsiness

Psychiatric/Emotional

Speech problems
Anxiety/stress
Problem with sleep/nightmares
Depression
Nail biting/thumb sucking
Bad temper/jealousy

Blood/Lymph

Unexplained lumps
Easy bruising/bleeding

Allergy

Hay Fever/itchy eyes

FCHC Medical Group

PHI Release Authorization

Patient Name: _____Date of Birth: _____

Address: _____

By signing this authorization form, you are agreeing to the release or disclosure of your protected health information. Your medical care or payment for care will not be conditioned on the signing of this form.

Please be aware that any information disclosed to a third party pursuant to this authorization may be subject to re-disclosure and no longer protected by our policies and applicable law.

This authorization will expire one year from the date of the signature below. You have the right to revoke this authorization by completing the revocation section below. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I hereby authorize _____ to release my protected health information to:

❑ FCHC Primary Care Delta
6696 US Highway 20A
Delta, OH 43515
Phone: 419-822-3242
Fax: 419-330-2641

❑ FCHC Primary Care Fayette
124 W Main St, PO Box 399
Fayette, OH 43521
Phone: 419-237-2501
Fax: 419-237-2671

❑ FCHC Primary Care Wauseon
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3242
Fax: 419-335-3222

❑ FCHC Orthopedics
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-2663
Fax: 419-335-9615

❑ FCHC OB/GYN
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-6377
Fax: 419-335-6807

❑ FCHC Pediatrics
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3333
Fax: 419-337-7845

❑ FCHC Behavioral Health
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-330-2790
Fax: 419-330-2774

❑ FCHC General Surgery
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-337-7478
Fax: 419-337-7846

❑ FCHC Urology
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-2000
Fax: 419-335-7500

❑ FCHC Urgent Care
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-337-7467
Fax: 419-337-7468

❑ FCHC Heart & Vascular
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-330-2653
Fax: 419-330-2656

The information to be disclosed may include information related to diagnosis and treatment for HIV, alcohol and/or substance abuse and mental illness.

Information and date(s) of service to be disclosed: _____

Purpose for disclosure: _____

Patient/Representative Signature:_____Date:_____

*****Revocation*** (Sign below ONLY if you wish to revoke this authorization)**

I hereby revoke this authorization

Patient/Representative Signature:_____Date:_____