



NORTHERN OHIO MEDICAL SPECIALISTS  
HEALTHCARE

2500 W. STRUB ROAD, STE 350  
SANDUSKY, OH 44870

### IN ORDER TO SERVE YOU BETTER

**Dr. Kresge** is working at the following locations:

Monday - 730 Jefferson St. Port Clinton  
Wednesday afternoon- 2500 W Strub Rd, Ste 350 Sandusky  
Thursday - 730 Jefferson St. Port Clinton  
Friday Morning - 2500 W Strub Rd, Ste 350 Sandusky

Your medical records will remain in the Sandusky office except for the day of your scheduled appointment in Port Clinton.

All information regarding your care can be obtained from the Sandusky office at 625-1236. This includes prescription refills and any problems or concerns that may arise between appointments.

All billing is done from the Central Billing office. Any questions should be directed to 419-609-1112, Monday through Friday from 9:00 am to 5:00 pm. As a courtesy our Central Billing office will submit all professional charges to your insurance company. However, **YOU** are ultimately responsible for all fees. Further concerns can be directed to our office at 419-625-1236.

There are certain patient payment responsibilities with all insurance carriers such as annual deductible, co-payment amounts, co-insurance, and non-covered services. These payments are expected at the time of the service. You may make payment by cash, check, money order, credit card, or Electronic Funds Transfer (EFT).

For those of you who require long-term medical care, we will be happy to establish a monthly payment schedule. Pre-payment of services is also available. If you are not covered by a health insurance, payment is due at the time of the service. If you are unable to make payment in full at the time of service, other arrangements can be made with the Central Billing office. If you have the Medical card not all services are covered by the medical card. The patient is responsible for such non-covered services.

If your problem is an accident or personal injury case, you will be self-pay with this office. Patient is responsible to pay for all charges at the time of each visit. This office will supply you with a ledger stating the amount due for your records and/or submission for reimbursement to another insurance carrier, upon your request and signature. (signature page private payor insurance policy).

If you are unable to keep an appointment, please be sure to call the office at least 24 hours in advance or you may be charged \$50.00.

## **DISABILITY FORMS**

Please have patient section completed before submitting form to this office. Please sign authorization for release of information in the patient section before submitting to this office. There is a \$15.00 charge per form which must be paid at the time the form is submitted to this office for completion. If forms are brought to the Port Clinton office location, there will be a slight delay in processing.

## **WORKER'S COMPENSATION FORMS**

There is no charge for completion of Worker's Compensation forms, C-84.

If this is a recent injury, and you have not obtained a number yet, this office still needs the date of injury, and employer at time of injury, MCO and MCO address.

If this is an old injury, no form can be completed until this office receives the W/C number, the allowed diagnosis with codes, and completion of W/C information sheet provided by this office.

## **COMMERCIAL INSURANCE**

If you have a **PPO** or **HMO** health insurance policy please call the insurance company to make sure you are in-network for not only office visits but any testing or treatment that the doctor may order. You also need to make sure that any services ordered are "covered services with your policy". Some insurance companies require pre-certification prior to having procedures performed or testing done. Once you have checked with the insurance company to make sure a specific procedure or test is a covered service please inquire as to whether pre-certification or predetermination is required. If this is required, please contact our office at 419-625-1236. The customer service phone number is usually located on the back of your insurance card or can be found in your policy manual.

If you have an **HMO** health insurance policy it is your responsibility to contact your primary care physician and request that a referral be submitted for the specialist and any testing/treatment ordered. Once a referral or authorization number is obtained, please inform this office of such. If a referral number is not obtained the patient will be rescheduled until a hard copy of the referral is presented.

Thank you for your cooperation.



NORTHERN OHIO MEDICAL SPECIALISTS  
HEALTHCARE

Date: \_\_\_\_\_

Patient Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: M S W D Do you have insurance through work?  Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Best time to reach you by phone: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Do you have insurance through work?  Yes  No

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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If you are covered under your parents insurance, OR a minor, you **MUST** complete the following:

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Are you covered under your mother's insurance?  Yes  No Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Check if below is same as above

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

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Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Are you covered under your father's insurance?  Yes  No Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Check if below is same as above

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

In case of emergency who should we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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### INSURANCE INFORMATION

We apologize for any inconvenience, but we **MUST** have a copy of your medical insurance cards before you can see the physician.

Primary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Check if below policy holder information is same as front

Date of Birth: \_\_\_\_\_ Sex:  M  F SS#: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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Secondary Insurance: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Check if below policy holder information is same as front

Date of Birth: \_\_\_\_\_ Sex:  M  F SS#: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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Is this a work related injury?  Yes  No

MCO: \_\_\_\_\_ Claim: \_\_\_\_\_

1st Report of Injury?  Yes  No Employer at time of injury: \_\_\_\_\_

Employer's Phone #: \_\_\_\_\_ Employer's Fax #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Initials of person completing form if other than patient: \_\_\_\_\_

## ORTHOPEDIC HEALTH QUESTIONNAIRE

Chief Complaint: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Name \_\_\_\_\_ Birthdate: \_\_\_\_\_

What medications are you taking (including nonprescription)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies \_\_\_\_\_  
 \_\_\_\_\_

### Medical History

Check the illness/conditions that apply to you.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Aids/ HIV                         | <input type="checkbox"/> CAD/ Heart Disease         | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Alcoholism                        | <input type="checkbox"/> Crohn's Disease            | <input type="checkbox"/> Inflammatory Bowel Disease    | <input type="checkbox"/> Psoriasis            |
| <input type="checkbox"/> Alzheimer's                       | <input type="checkbox"/> Degenerative Joint Disease | <input type="checkbox"/> Juvenile Rheumatoid Arthritis | <input type="checkbox"/> PVD                  |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Kidney Disease                | <input type="checkbox"/> Renal Disease        |
| <input type="checkbox"/> Angina                            | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Liver Disease                 | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Drug abuse                 | <input type="checkbox"/> Lyme disease                  | <input type="checkbox"/> Scoliosis            |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> DVT                        | <input type="checkbox"/> Migraine Headaches            | <input type="checkbox"/> Seizure Disorder     |
| <input type="checkbox"/> Atrial fibrillation               | <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Multiple Sclerosis            | <input type="checkbox"/> Sleep Apnea          |
| <input type="checkbox"/> BPH/Enlarged Prostate             | <input type="checkbox"/> Gallbladder Disease        | <input type="checkbox"/> MI/Heart Attack               | <input type="checkbox"/> SLE/ Lupus           |
| <input type="checkbox"/> Cancer: If yes, which type? _____ | <input type="checkbox"/> GERD                       | <input type="checkbox"/> Obesity                       | <input type="checkbox"/> Spinal Stenosis      |
| <input type="checkbox"/> CVA/ Stroke                       | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Osteoarthritis                | <input type="checkbox"/> Spondyloarthopathy   |
| <input type="checkbox"/> Congestive Heart Failure          | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Osteoporosis                  | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> COPD/ Emphysema                   | <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Parkinson's Disease           | <input type="checkbox"/> Heart Valve Disease  |

Other illnesses \_\_\_\_\_

### Past Surgical History

	Year		Year		Year
ACL Surgery		Carpal Tunnel Release		Meniscus Surgery	
Angioplasty		Cataract Extraction		Muscle Biopsy	
Angio w/ Stent		Cholecystectomy		ORIF	
Appendectomy		Colectomy		Pacemaker	
Arthroscopy Ankle		Colostomy		Rotator Cuff Repair	
Arthroscopy Elbow		Discectomy		Small Bowel Resection	
Arthroscopy Hip		Gastric Bypass		Thyroidectomy	
Arthroscopy Knee		Hernia Repair		Tonsillectomy	
Arthroscopy Wrist		Hip Arthroplasty		<b>Gender Specific</b>	
Arthroscopy Shoulder		Hip Replacement		Cesarean section	
Back Surgery		Knee Replacement		Hysterectomy	
CABG		Laminectomy		Mastectomy	
Heart Valve Replacement		LASIK			

Other Surgeries \_\_\_\_\_

**Review of Systems**

Are you experiencing any of the following symptoms?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> fatigue/tiredness                     | <input type="checkbox"/> vomiting                  | <input type="checkbox"/> difficulty walking      |
| <input type="checkbox"/> night sweats                          | <input type="checkbox"/> menstrual cramps          | <input type="checkbox"/> dizziness               |
| <input type="checkbox"/> vision loss                           | <input type="checkbox"/> difficulty with urination | <input type="checkbox"/> headaches               |
| <input type="checkbox"/> cough                                 | <input type="checkbox"/> blood in the urine        | <input type="checkbox"/> rash                    |
| <input type="checkbox"/> shortness of breath                   | <input type="checkbox"/> heavy menses              | <input type="checkbox"/> bone/joint symptoms     |
| <input type="checkbox"/> chest pain                            | <input type="checkbox"/> vaginal discharge         | <input type="checkbox"/> weakness                |
| <input type="checkbox"/> claudication/poor circulation in legs | <input type="checkbox"/> cold intolerance          | <input type="checkbox"/> bleeding                |
| <input type="checkbox"/> cyanosis                              | <input type="checkbox"/> heat intolerance          | <input type="checkbox"/> easy bruising           |
| <input type="checkbox"/> irregular heartbeat/palpitations      | <input type="checkbox"/> anxiety                   | <input type="checkbox"/> environmental allergies |
| <input type="checkbox"/> constipation                          | <input type="checkbox"/> depression                | <input type="checkbox"/> food allergies          |
| <input type="checkbox"/> diarrhea                              |  |  |

**Social History**

Hand Dominance:  Right  Left  Ambidextrous

Activity Level:  Moderate  Vigorous  Sedentary

Type of Exercise \_\_\_\_\_ Frequency \_\_\_\_\_

Do you use tobacco?  Yes  No  Former Quit in (year) \_\_\_\_\_  
 Type of Tobacco \_\_\_\_\_ Packs per day \_\_\_\_\_ Number of Years smoked \_\_\_\_\_

Do you drink alcohol?  Yes  No  Former Quit in (year) \_\_\_\_\_  
 Type of Alcohol \_\_\_\_\_ Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Last Drink \_\_\_\_\_

Use of Caffeine  Yes  No  
 Type of Caffeine \_\_\_\_\_ Amount Daily \_\_\_\_\_

Occupation /Work \_\_\_\_\_

**Family History**

Please list relatives to you that have had any of the following conditions and identify their relationship to you.

	Relationship		Relationship
Alive and Well		Gout	
Alcoholism		Hearing Impairment	
Allergies		Hodgkin's Disease	
Alzheimer's Disease		High Cholesterol	
Asthma		High Blood Pressure	
Anemia		Kidney Disease	
Blood Disease		Liver Disease	
Bone Cancer		Mental Illness	
Heart Disease		Migraines	
Cancer (What type?)		Muscle Disease	
Congenital Heart Disease		Obesity	
Colitis		Osteoarthritis	
Congestive Heart Failure		Osteoporosis	
CVA (stroke)		Parkinson's Disease	
Depression		Vascular Disease	
Developmental Delay		Seizure Disorder	
Diabetes		Thyroid Disorder	
Drug Abuse		Others	



*"Setting the Standard for Excellence in Healthcare."*

**PATIENT ACKNOWLEDGEMENT**

**Ears, Nose & Throat**  
Paul S. Biedenbach, D.O.  
Jeffrey S. Christoff, D.O.  
Benjamin W. Murcek, D.O.  
Hilary H. Timmis, M.D.

**Family Practice**  
Rugen M. Alda, M.D.  
Brian A. Baxter, M.D.  
Andrew R. Bejarano, D.O.  
Mary F. Bower, M.D.  
Paul J. Bruner, D.O.  
Jessica L. Crow, D.O.  
Christopher J. Emery, D.O.  
Edward J. Hemeyer, M.D.  
Jennifer G. Hohman, M.D.  
G. Robert Kaftan, D.O.  
Kari M. Ketvertis, M.D.  
Susan S. Perng, M.D.  
Allison M. Petznick, D.O.  
Matthew Petznick, D.O.  
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Michele L. Ralofsky, M.D.  
John F. Ramey, D.O.  
Thomas D. Rowe, M.D.  
Carrie A. Collins, CNP  
Julie C. Lehrer, CNP

**General Psychiatry**  
Cynthia L. Evans, M.D.

**General Surgery**  
Philip M. Hutchison, D.O.  
Robert G. Kloos, D.O.  
Horace D. Christian II, M.D.

**Gastroenterology**  
Siva S. Nair, M.D.

**Internal Medicine**  
Daniel B. Barry II, M.D.  
Jeffrey A. Garman, D.O.  
Archana A. Gorty, M.D.  
Robert L. Hill, M.D.  
Lee A. Pietrangelo, M.D.  
Robert J. Vaschak, D.O.  
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Lisa E. Dendinger, CNP  
Michele L. Poulos, CNP

**OB/GYN**  
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Rick A. Visci, D.O.  
Laura A. Griffaw, CNM  
Judith K. Lamp, CNM  
Dianne M. Mawhirtter, CNP  
Joanne M. Palun, CNP

**Orthopaedics**  
J. Andrew Huddleston, D.O.  
Gary D. Kresge, D.O.  
Timothy R. Lynch, D.O.  
David A. Pocos, D.O.  
Michael T. Powers, D.O.  
Steven B. Shine, D.O.  
Karen M. Hemmer, P.A.

**Neurology**  
Mark D. Bej, M.D.

**Physical Medicine & Rehabilitation/  
Pain Management**  
Gregory J. Gerber, M.D.

**Podiatry**  
Eugene R. Kubitz, DPM, CWS  
John S. Liebenthal, DPM, CWS

**Occupational Medicine & Urgent Care**  
Anthony G. Tesmond, D.O.  
Tiffany L. Worthington, D.O.  
Kathleen F. Stierwalt, CNP  
Margaret G. Sullivan, CNP

**Administration**  
Bradley P. Smith,  
MBA, FACHE, FHFMA, CMPE  
Chief Executive Officer  
2500 W. Strub Rd., Suite 360  
Sandusky, Ohio 44870  
(419) 626-6161  
(419) 626-7030 Fax

I hereby permit Northern Ohio Medical Specialists to release any information acquired throughout the course of my examination and treatment as needed to process any claims on my behalf.

Initial Here

I HEREBY AGREE TO PAY ANY AND ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AMOUNTS OVER UCR, AND/OR EXCLUDED CHARGES FROM INSURANCE COMPANIES WITH WHOM NORTHERN OHIO MEDICAL SPECIALISTS DOES NOT ACCEPT ASSIGNMENT, AND ANY AND ALL CO-PAYS, DEDUCTIBLES AND CO-INSURANCE WITH THOSE THEY DO ACCEPT ASSIGNMENT.

**PAYMENT AUTHORIZATION:** I hereby request my insurance carrier to pay on my behalf insurance benefits to Northern Ohio Medical Specialists for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, a credit bureau report may be obtained. Northern Ohio Medical Specialists cannot be held responsible for collecting my insurance claim(s) nor for negotiating a settlement(s) on a disputed claim(s). Northern Ohio Medical Specialists fees are not established by insurance companies. I am responsible for my account.

Initial Here

I hereby understand that Northern Ohio Medical Specialists has a posted No-Show Policy and that if I do not cancel an appointment 24 hours prior to the scheduled appointment, I may be subject to the fees associated with said policy.

Initial Here

I hereby agree, in accordance with HIPAA regulations, that I have been advised of Northern Ohio Medical Specialists privacy policy. I permit NOMS to release or obtain any information throughout the course of my examination and treatment as needed to process any claims on my behalf. I permit Northern Ohio Medical Specialists to send me any information via mail or by calling the telephone number(s) I have authorized below, regarding my account, treatment, appointments and/or any advertisements or specials offered by the offices. In the event that I cannot be reached directly, I give my consent for Northern Ohio Medical Specialists to leave a message on my voice mail, answering machine, or with any individual who answers any of the telephone numbers that I have listed below.

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Signature

Date

This authorization is valid until revoked in writing.

Revised 2/2010



PATIENT CONTACT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I wish to be contacted in the following manner (check all that apply):

Oral Communication:

- Home Phone, Work Phone, OK to leave message with detailed information, Leave message with call-back number only, Other

Written Communication:

- OK to mail to my home address, OK to mail to my work/office address, OK to fax to, Other

I permit the Practice to discuss my PHI with, and to disclose my PHI to, the following Individuals:

- Spouse, Adult Child(ren), Parent(s), Personal Representative

If checked, the following additional instructions apply:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by patient's authorized representative, describe the representative's authority:

- Patient is a minor; I am the patient's parent and natural guardian
Patient is a minor; I am the patient's guardian, appointed by the County Juvenile Court
Patient is a ward; I am the patient's guardian, appointed by the County Probate Court
Patient is deceased. I am the patient's surviving spouse.
Patient is deceased. I am the executor or administrator of the patients estate, appointed by the County Probate Court
I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care
Other