Welcome to Saint Vincent.
Welcome to better care.

The Saint Vincent Medical Group consists of 19 family and internal medicine practices conveniently located throughout Erie and its surrounding communities—including doctors' offices in Albion, Edinboro and Union City.

From sudden injury and illness to preventive screenings and immunizations, our board-certified physicians are dedicated to providing you and your loved ones with the most innovative, compassionate care possible.

Choosing the right primary care physician is one of the most important decisions you can make in life. That's why we make it so simple to make the switch.

1. Review the comprehensive primary care practice listing found in this kit and select the physician of your choice.*

2. Complete and sign all patient information, insurance and medical history forms.

3. Mail all forms to:
   Saint Vincent Medical Group
   1910 Sassafras St
   Suite 100
   Erie, PA 16502

We welcome the opportunity to care for you and your family. We will be in touch shortly to review your information and schedule an appointment with your new physician.

** If you need assistance choosing a specific practice or physician, call our Referral Center at (814) 452-SVMG (7864) or visit SwitchToSV.com. If the physician you have selected is not currently accepting new patients, we will work with you to choose another physician based upon your individual health care needs.*

Saint Vincent Hospital

2014 Saint Vincent *Medical Group Listing*

Saint Vincent Hospital

232 West 25 Street | Erie, PA 16544 | 814.452.5000 | AHN.org

ALBION FAMILY PRACTICE

155 East State Street
Albion • 814.756.4917

Peter Kroemer, MD

ASBURY FAMILY MEDICINE

4671 West Lake Road
Erie • 814.835.2041

Mark Leone, DO

CHILDREN'S HEALTH CARE—WEST

Specializing in Pediatrics

2501 West 12 Street
Erie • 814.835.4838

Susan Moore, MD

Anne Marie Zomcik, MD

ELK VALLEY MEDICAL CENTER

5165 Imperial Parkway
Girard • 814.774.3128

Joshua Czerwinski, DO

Wes Hilbert, MD

Lisa Treusch, MD

EDINBORO MEDICAL CENTER

450 Erie Street • Edinboro • 814.734.1618

Travis Bishop, DO

Sam Reynolds, MD

William Getson, MD

John Streiff, MD

Text Message Appointment Reminders

Now Available for Saint Vincent Medical Group Patients

Sign up to receive text message appointment reminders on your cell phone. **It's easy!** Make sure your Saint Vincent Medical Group physician office has your cell phone number.

Text SVMG to 622622.

Message and data rates may apply. Text HELP to 622622 to receive help or STOP to opt-out.

EAST HARBOR PRIMARY CARE

4950 Buffalo Road
Erie • 814.899.7000

Maggie Biebel, DO

LIBERTY FAMILY PRACTICE

3413 Cherry Street
Erie • 814.868.9828

Bradley Fox, MD

GREAT LAKES FAMILY MEDICINE

3530 Peach Street
Erie • 814.864.6039

James Jageman, MD

David Overare, MD

Stephanie Traud, DO

MILLCREEK FAMILY PRACTICE

145 West 23 Street, Suite 101
Erie • 814.461.6626

Geoffrey Betz, MD

Joseph Deimel, MD

Christopher Serafini, DO

Allison Snyder, DO

Kelli Wienecke, DO

Saint Vincent Hospital

PORT ERIE FAMILY MEDICINE

3413 Cherry Street
Erie • 814.860.5970


Deborah Ranish, MD


Linda Young, MD

MCCLELLAND FAMILY PRACTICE

2240 East 38 Street, Suite 200
Erie • 814.825.4262


Terence Lillis, MD


Mark Masteller, DO


James Steele, DO

SAINT VINCENT PRIMARY CARE AT YORKTOWN

2501 West 12 Street
Erie • 814.835.3302

SAINT VINCENT INTERNAL MEDICINE

145 West 23 Street, Suite 101
Erie • 814.452.7875


John Mingey, MD

SAINT VINCENT SPORTS MEDICINE

4671 West Lake Road
Erie • 814.835.2035

Including Primary Care


Jeffrey Kim, DO


Philip St. Julien, DO


Laura McIntosh, MD

SAINT VINCENT FAMILY MEDICINE CENTER

311 West 24 Street, Suite 305 • Erie • 814.454.4484

Family Practice


Caitlin Clark, DO


Timothy Pelkowski, MD


Bruce Gebhardt, MD


Gary Silko, MD


Robert Mikelonis, MD

Internal Medicine


Dorothy Candib, MD

Pediatrics


Lucy Lot, MD

UNION CITY FAMILY PRACTICE

130 North Main Street
Union City • 814.438.7208


Thomas Slokan, DO

WEST RIDGE FAMILY PRACTICE

4535 West Ridge Road
Erie • 814.833.2902


Paul Gausman, DO


Jillian Halmi, DO

WESTMINSTER FAMILY MEDICINE

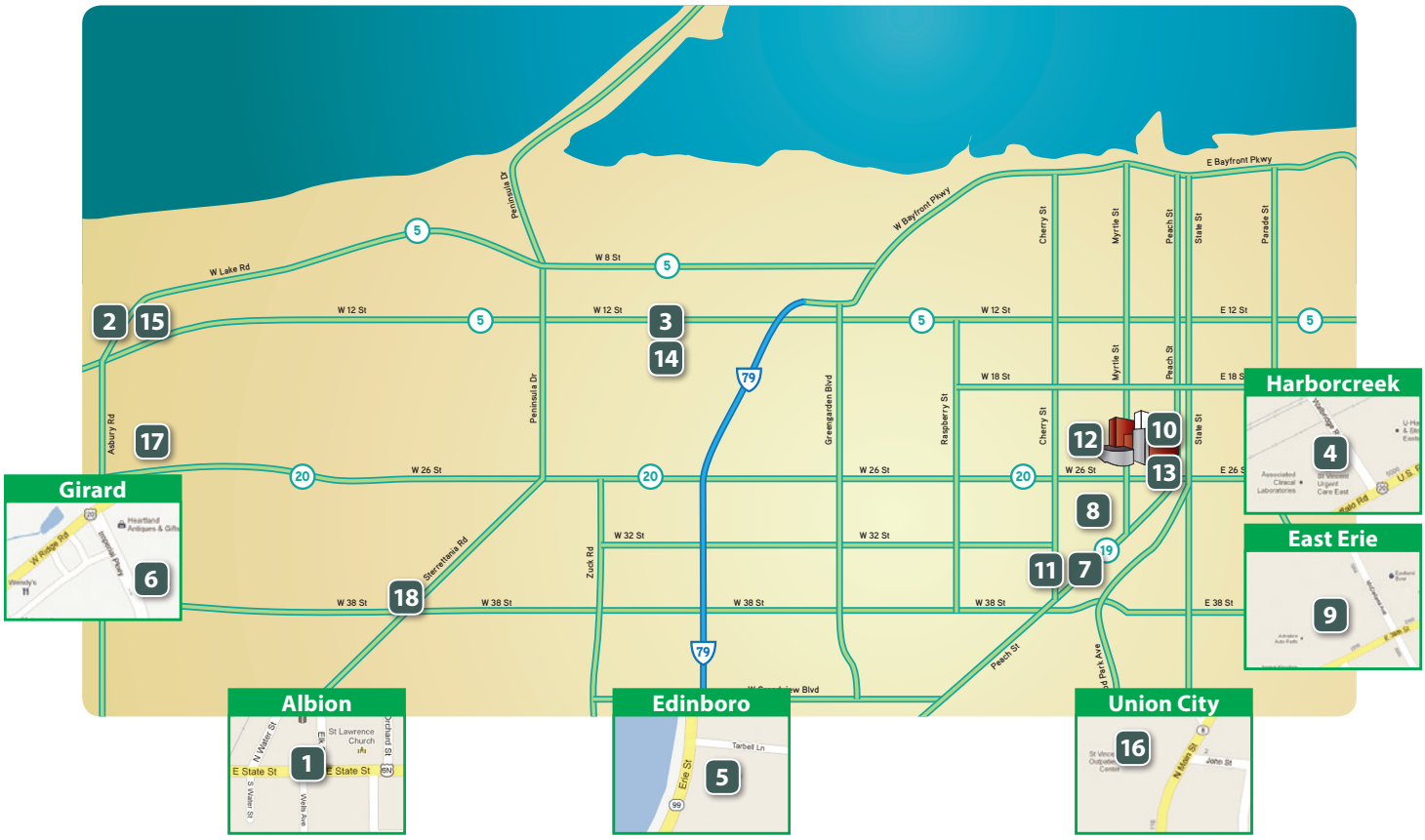
3822 Colonial Avenue, Suite A
Erie • 814.833.5653


Warren Beaver, MD


Jeffrey Clemente, MD


Richard Cogley, MD


Jack Yakish, MD



1. Albion Family Practice
2. Asbury Family Medicine
3. Children's Health Care—West
4. East Harbor Primary Care
5. Edinboro Medical Center
6. Elk Valley Medical Center
7. Great Lakes Family Medicine
8. Liberty Family Practice
9. McClelland Family Practice
10. Millcreek Family Practice
11. Port Erie Family Medicine
12. Saint Vincent Family Medicine Center
13. Saint Vincent Internal Medicine Group
14. Saint Vincent Primary Care at Yorktown
15. Saint Vincent Sports Medicine
16. Union City Family Practice
17. West Ridge Family Practice
18. Westminister Family Medicine

Important Telephone Numbers

Saint Vincent Hospital
814.452.5000

Saint Vincent Emergency Department
814.452.5353

Saint Vincent Urgent Care-East
814.898.2576

Patient Room Information
814.452.5800

Saint Vincent Imaging Center/Yorktown
814.838.2085

Find a Saint Vincent Physician
814.452.5500

Saint Vincent Financial Services
814.452.5011

Saint Vincent Medical Records
814.452.5070

Referral Center
814.452.SVMG (7864)

If you need assistance choosing a specific practice or physician, call our Referral Center at 814.452.SVMG (7864) or visit SwitchToSV.com

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Medical Record Release Form

Saint Vincent Hospital

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Medical Record)

Note to Recipient of Information: The patient's medical information is privileged and is protected by various state and federal laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

1 I, _____ born _____
(Patient's Name) *(Date of Birth)*

_____
(Street Address) *(City, State, Zip)*

Authorize the entity listed below, to release to the party listed in paragraph 2 the following information from my medical records:

_____
(*Name of Entity)*

_____
(Street Address) *(City, State, Zip)*

(Check appropriate items)

☐ Current medical record, or

☐ Other

for the following dates of treatment:_____

NOTE: Mental Health, drug/alcohol or HIV-related information, if contained in the medical record, **will be released** through this authorization unless otherwise indicated. Check below if you do not want this information released.

___ Do not release mental health information

___ Do not release drug and/or alcohol information

___ Do not release HIV information

2 My medical information may be inspected by and/or copies may be released to:

_____
(*Name of Recipient)*

_____
(Street Address) *(City, State, Zip)*

for the purpose of _____

(Note: it will be assumed the purpose is at the request of the individual signing this release unless otherwise stated.)

3. I may revoke this authorization in writing at any time (except to the extent that actions have been taken in reliance upon it.)

4. I understand that the Saint Vincent entity listed above may not condition treatment on whether I sign this authorization.

5. Unless revoked or renewed in writing, this authorization will expire on (Date): _____.

6. I understand the possibility that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal Privacy Regulations.

If the expiration date is not specified above, this authorization will automatically expire 12 months from the date signed below.

Patient Signature _____ **Date** _____

If patient is a minor, subject to a guardianship, power-of-attorney, or is deceased, I have signed my name below on behalf of the patient and myself.

_____

(Patient's, Legal Guardian's or Agent's Signature) *(Relationship to Patient)* *(Date Signed)*

I witnessed the signature on this form: Name of witness: (Please Print)

_____

Witness' Signature _____ **Date** _____

Patient Information

Saint Vincent Hospital

Preferred Physician/Practice _____
(Please refer to the primary care practice listing enclosed in this kit)

Name _____
(Last) *(First)* *(Middle)*

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____

Date of Birth _____ Age _____ Marital Status _____

Employer _____ Employer Phone _____

Emergency Contact and Phone Number _____

(relationship) _____

Pharmacy most often used _____

Insurance Information

Insurance Co. Name: _____

Primary Insurance Holder: _____ Date of Birth: _____

Address: _____

Relationship: _____

Male/Female: _____

Policy #: _____

Group #: _____

Secondary Insurance: _____

Secondary Insurance Holder: _____

Policy #: _____

Group #: _____

Patient Signature: _____ Date: _____

Saint Vincent Hospital

Adult Health History Form

Patient Name: _____

Date of Birth: _____ **Age:** _____

If you are not sure how to answer any of the questions on this form, please ask the nurse or doctor for help.

Medical History

Have you ever been told by a doctor that you had any of the following medical conditions? Check those that apply. If you do not have any past or present medical conditions, check "None":

❑ **None** – No Past or Present Medical Conditions

Cardiovascular — Heart Diseases/Conditions

❑ Coronary Artery Disease (CAD)
❑ Heart Attack — Prior Myocardial Infarction
❑ High Blood Pressure — Hypertension
❑ Congestive Heart Failure (CHF)
❑ High Cholesterol — Hyperlipidemia
❑ Peripheral Vascular Disease (PVD)
❑ Atrial Fibrillation
❑ Murmur

Cancer

❑ Brain
❑ Breast
❑ Bone
❑ Skin
❑ Leukemia (Blood)
❑ Lung
❑ Colon
❑ Throat
❑ Prostate (male)
❑ Other: _____

Endocrine

❑ High Blood Sugar — Diabetes
❑ Thyroid Disorder
❑ Menopause/Hot Flashes
❑ Obesity (Overweight)

Gastrointestinal — Digestive Diseases/Conditions

❑ Acid Reflux — Esophageal Reflux
❑ Stomach Ulcers — Peptic Ulcer
❑ Inflammation of Liver — Hepatitis
❑ Gallbladder Problems
❑ Inflammation of Colon — Acute Colitis
❑ Liver Damage — Cirrhosis
❑ Irritable Bowel Syndrome

Hematological — Blood Conditions

❑ Low Iron — Anemia
❑ Blood Clots in Legs — DVT
❑ Blood Problems — Specify: _____

Immunological

❑ Allergies

Infectious Disease

❑ HIV
❑ AIDS
❑ TB (Tuberculosis)

Mental Health Conditions

❑ Depression (sadness)
❑ Anxiety (nervousness)
❑ Bipolar
❑ Other: _____

Musculoskeletal — Bone Conditions

❑ Ruptured Disc — Intervertebral Disc Degeneration
❑ Aching Joints — Osteoarthritis
❑ Calcium Depletion — Osteoporosis
❑ Other: _____

Adult Health History Form

Medical History

Neurological

❑ Migraine Headache

❑ Convulsions/Seizures

❑ Stroke — CVA/TIA

❑ Alzheimer's — Dementia

Pulmonary – Lung Diseases/Conditions

❑ Chronic Obstructive Pulmonary Disease (COPD)

❑ Asthma

❑ Ear Infections — Otitis Media

❑ Pneumonia

❑ Sinus Infections — Sinusitis

❑ Sleep Apnea (Stop breathing during sleep)

❑ Emphysema (Lung Problem)

Sensory

❑ Eye — Cataracts

❑ Eye — Glaucoma

❑ Blindness

❑ Hearing Loss

Renal(Kidney)/Urinary Conditions

❑ Renal/Kidney Failure

❑ Renal/Kidney Disorder — Specify: _____

❑ Urinary Tract/Bladder Infection

❑ Kidney Stones — Nephrolithiasis

❑ Enlarged Prostate — BPH

Please list any other medical conditions not indicated above:

_____

_____

Do you have an eye doctor? ❑ Yes ❑ No

If yes, please write the name of your eye doctor: _____

Please indicate the dates of your last tetanus, pneumonia and flu shots.

Tetanus	Pneumonia	Flu

Please indicate the dates and results of the testing listed below.

	Colonoscopy	Pap (Women only)	Mammogram (Women only)	Prostate Exam (Men only)
Date:				
Abnormal?				
If abnormal, please explain.				

Surgical History

Have you ever had a surgical procedure or operation? ❑ Yes ❑ No

If yes, list the procedure/operation, the date of the procedure/operation and your age at the time.

Precedure/Operation	Date	Age
1.		
2.		
3.		
4.		
5.		

Adult Health History Form

Medications

Are you currently taking any medications (prescription and/or over the counter)**?** ❑ Yes ❑ No

If yes, list the medication, dose and instructions

Name of Medication	Dose & Instructions
Example: Ibuprophen — Advil	800mg — 2 times a day
1.	
2.	
3.	
4.	
5.	
6.	

Allergies

Do you have any allergies? ❑ Yes ❑ No

If yes, list the allergy and reaction.

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Family History

We realize that medical information on relatives is sometimes quite limited. Complete the questions below to the best of your knowledge. If you are unable to provide medical history information on your biological relatives, please check the box below and continue onto the next page.

❑ **Unable to Provide Family History Information.**

Please check the appropriate box below to indicate family history of blood relatives. (GM = Grandmother, GF = Grandfather)

	Mother	Father	Siblings	(Mother's side) GM	(Mother's side) GF	(Father's side) GM	(Father's side) GF
Coronary Artery Disease (Heart)	❑	❑	❑	❑	❑	❑	❑
Congestive Heart Failure	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure — Hypertension	❑	❑	❑	❑	❑	❑	❑
Respiratory/Lung Disorder	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
COPD	❑	❑	❑	❑	❑	❑	❑
Emphysema (Lung Problem)	❑	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑	❑

Adult Health History Form

Family History

	Mother	Father	Siblings	(Mother's side) GM	(Mother's side) GF	(Father's side) GM	(Father's side) GF
Hepatic Problems (Liver Problems)	❑	❑	❑	❑	❑	❑	❑
Renal/Kidney Disease	❑	❑	❑	❑	❑	❑	❑
High Cholesterol — Hyperlipidemia	❑	❑	❑	❑	❑	❑	❑
Thyroid Problems	❑	❑	❑	❑	❑	❑	❑
Calcium Depletion — Osteoporosis	❑	❑	❑	❑	❑	❑	❑
High Blood Sugar — Diabetes Mellitus	❑	❑	❑	❑	❑	❑	❑
Joint Problems — Arthritis	❑	❑	❑	❑	❑	❑	❑
Migraine Headaches	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑
Mental Retardation	❑	❑	❑	❑	❑	❑	❑
Mental Health Conditions (Depression, Anxiety, etc.)	❑	❑	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑	❑	❑
Hematologic/Blood Problems (Sickle Cell, Bleeding Problems, etc.)	❑	❑	❑	❑	❑	❑	❑
Cancer — Specify type: _____	❑	❑	❑	❑	❑	❑	❑
Colon Cancer — Malignant Neoplasm	❑	❑	❑	❑	❑	❑	❑
Lung Cancer	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑
Ovarian Cancer	❑	❑	❑	❑	❑	❑	❑
Cervical Cancer	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑
Sudden Death — Explain: _____	❑	❑	❑	❑	❑	❑	❑

Personal/Social History

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑ White

Ethnicity: ❑ African American ❑ American ❑ Arabian ❑ Asian-Indian ❑ Australian ❑ Austrian ❑ Bavarian ❑ British ❑ Chinese ❑ Eastern European ❑ European ❑ Filipino ❑ French ❑ German ❑ Hispanic ❑ Irish ❑ Italian ❑ Japanese ❑ Jewish ❑ Korean ❑ Mexican ❑ Polish ❑ Puerto Rican ❑ Russian ❑ Scotch Irish ❑ Scottish ❑ Spanish ❑ Other

What is your primary language? _____

Are you adopted? ❑ Yes ❑ No

Do you drink beverages that have caffeine? ❑ Yes ❑ No

If Yes: What do you drink? ❑ Coffee ❑ Pop ❑ Tea ❑ Other: _____

How many cups per day do you drink? _____

Do you use tobacco? ❑ Yes ❑ No

If Yes: What type of tobacco do you use? ❑ Cigarettes ❑ Cigar ❑ Pipe ❑ Chew

Have you smoked within the last twelve (12) months? ❑ Yes ❑ No

Adult Health History Form

Personal/Social History

How many packs a day do you smoke? _____

How many years have you smoked? _____

If you have quit smoking, what year did you stop smoking? _____

Are you exposed to second hand smoke? ❑ Yes ❑ No

Do you drink alcoholic beverages? ❑ Yes ❑ No

If Yes: What do you drink? ❑ Beer ❑ Wine ❑ Hard Liquor ❑ Other: _____

How often do you drink? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Other: _____

When was the last time you drank alcohol? _____

Do you use illegal drugs? ❑ Yes ❑ No

If Yes: What type of drugs do you use? ❑ Marijuana ❑ Cocaine ❑ Heroin ❑ Other: _____

How often do you use drugs? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Other: _____

When was the last time you used drugs? _____

Do you use sun screen? ❑ Yes ❑ No

Do you wear a seatbelt? ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No

If Yes: How often do you exercise? _____

What type of exercise do you do? _____

What is your marital status? ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Who do you live with? _____

School History: Do you have a ❑ GED ❑ High School Diploma ❑ Trade School Degree ❑ College Degree

If you did not complete High School or get your GED, what is the last grade you completed: _____

Work History: Are you ❑ Unemployed ❑ Employed Part-time ❑ Employed Full-time ❑ Retired ❑ Disabled

If employed, what is your job/occupation? _____

If disabled, please explain. _____

Are you sexually active? ❑ Yes ❑ No

If Yes: Are you using birth control? ❑ Yes ❑ No

If Yes: What method of birth control do you use? ❑ Condoms ❑ Birth Control Pills ❑ Other: _____

Nutrition/Food

What is your average daily caloric intake: ❑ less than 1800 calories per day ❑ greater than 1800 calories per day

Do you currently take a multi-vitamin? ❑ Yes ❑ No If yes, what kind? _____

Do you currently take a calcium supplement? ❑ Yes ❑ No

How would you rate your current eating habits? ❑ Good ❑ Fair ❑ Poor

How many times per week on average do you eat out? _____

Are you currently following a special diet? ❑ Yes ❑ No Specify: _____

Living Will

Do you have a living will? ❑ Yes ❑ No

Manage your health care online anytime!

At Saint Vincent, we know how challenging it can be to fit managing your health care into everyday life. Sign up for mySV, Saint Vincent's online patient portal, and you can:

- Request appointments
- Renew prescriptions
- Pay office bills
- Ask questions of the doctor, nurse or biller
- Receive text message reminders

Signing up for mySV is easy.

- **Visit AHN.org/MySV.**
- **Click** 

- **Click** 

- **Follow the instructions on the screen.**

Saint Vincent Hospital