McPherson
CENTER FOR HEALTH

General Surgery

Clayton D. Fetsch, MD, FACS
Brandon J. Stringer, MD

OB/GYN

Bret E. Heskett, MD, FACOG

Family Medicine

David L. Buller, MD
Melisa Cooper, PA-C
Sheila W. Gorman, MD
Jill Sigsbee, PA-C
Tracy Sweat, PA-C
John D. Mosier, DO
Gregory M. Thomas, MD
Carl E. Turner, DO
Trenton J. VanEaton, MD
Nick Vogts, PA-C
Ruth Lehman Wiens, MD
Autumn Wilgers, NP-C, APRN

New Patient Form

Patient Name (Please Print) _____

Thank you for your interest in receiving care from one of our outstanding providers at McPherson Medical and Surgical Associates. Below is a listing of our providers. If you have a request for a provider, please denote that or simply select "No Preference" and we will take care of the rest. We work hard to connect you with a provider to meet your individual needs, but cannot guarantee a specific provider's availability.

- David L. Buller, MD
- Sheila W. Gorman, MD
- John D. Mosier, DO
- Greg M. Thomas, MD
- Carl E. Turner, DO
- Trenton J. VanEaton, MD
- Ruth Lehman Wiens, MD
- Autumn Wilgers, NP-C, APRN
- No Preference for Provider

You will receive follow-up communication from our office regarding your request as soon as possible.

This does not obligate you to stay with this provider. Thank you for your business.

Office Use Only

Date Patient Contacted_____ Date Received_____

McPherson HOSPITAL

McPherson Medical and Surgical Associates
1000 Hospital Drive • McPherson, Kansas 67460

PATIENT INFORMATION (Please Print) Date: _____

Name _____ Sex ☐ M ☐ F Age: _____

Address _____ Birthdate _____

City _____ State _____ Zip _____ Phone _____

Email _____ Cell Phone _____

Social Security # _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employer _____ Occupation _____

Business Address _____ State _____ Zip _____ Phone _____

If patient is a minor:

Mother's Name _____ Primary Phone _____ Work Phone _____

Father's Name _____ Primary Phone _____ Work Phone _____

RESPONSIBLE PARTY / PRIMARY INSURANCE INFORMATION

Insured's Name _____ Relation to Patient _____

Insured's Birthdate _____ Social Security # _____ Work Phone _____

Insured Employed by _____ Address _____

Insurance Company _____ Group # _____ ID# _____

Insurance Address _____ City _____ State _____ Zip _____

Do you have additional insurance: ☐ Yes ☐ No If yes, please complete the following:

Insured's Name _____ Relation to Patient _____

Insured's Birthdate _____ Social Security # _____ Work Phone _____

Insured Employed by _____ Address _____

Insurance Company _____ Group # _____ ID# _____

Insurance Address _____ City _____ State _____ Zip _____

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment.
I hereby assign payments for all medical services rendered to McPherson Medical and Surgical Associates.
I acknowledge that I am responsible for payment for all charges incurred that may not be covered due to a required co-payment, insurance deductible or classified by my insurance as non-covered services.

Signature _____ Relationship _____ Date _____

Notice: Your health information related to work-related illnesses or injuries or medical surveillance of the workplace may disclosed to your employer.

ACKNOWLEGMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the McPherson Medical and Surgical Associates Notice of Privacy Practices.

Signature _____ Date _____

McPherson HOSPITAL

NEW PATIENT HEALTH HISTORY FORM

Today's Date: _____

Name (Last, First MI)	Date of Birth

Present Health Concerns:

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis.

☐ Blood Clots	☐ Asthma	☐ High Blood Pressure
☐ Cancer	☐ Hearing Loss	☐ Migraine Headaches
Type:	☐ Heart Problems	☐Stroke
Date:	☐ Valvular (mitral/aortic)	☐ Thyroid Problems
☐ Concussion	☐ Rhythm (a-fib)	
☐ Depression	☐ Blockage (heart attack)	☐ Other
☐ Diabetes	☐ Other	
☐ Type I		
☐ Type II	☐ High Cholesterol	

Surgical History: (Please list all other prior operations and dates)

Operation	Date	Operation	Date

Procedure History: (Please list all prior procedures and dates, i.e. Colonoscopy, Bone Density Scan, Heart Cath, Stress Test)

Procedure	Date	Procedure	Date

Women's Gynecological History:

# of Pregnancies	# of Deliveries	# of Abortions	# of Miscarriages
1st day of most recent period	Age at 1st period	Frequency of periods	Length of each
Last Pap Smear Abnormal ☐ Yes ☐ No Date:		Last Mammogram Abnormal ☐ Yes ☐ No Date:	

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

McPherson HOSPITAL

NEW PATIENT HEALTH HISTORY FORM

Today's Date: _____

Family History:

Relative	Year of Birth	Age of Death	Cause of Death	**Health Issues** (diabetes, high blood pressure, depression, cancer, etc.)
Father				
Mother				
Siblings (Please circle one)				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Maternal Grandmother / Grandfather				
Paternal Grandmother / Grandfather				
Other				

Social History:

Occupation:	Marital Status (Circle One) Single / Married / Widowed / Divorced
Advance Directives: ☐ DNR ☐Living Will ☐Power of Attorney ☐ Living Arrangements	Alcohol Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use ☐ Prior Use Quit Date: _____
Caffeine Intake: ☐ Never ☐ Occasional ☐ Daily	Amount per week: _____
Tobacco: ☐ Current – Type :_____ Freq: _____ ☐ 2nd Hand ☐ Never ☐ Prior Use Quit Date: _____	Drug Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use ☐ Prior Use Quit Date: _____ History of Drug Abuse: _____

Medications: Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs. If more space is needed you can attach a list. **BRING ALL OF YOUR MEDICATIONS TO YOUR FIRST APPOINTMENT.**

Medication	Dose	Times per day	Medication	Dose	Times per day

Allergies or Reactins to Medicines / Food / Other Agents: ☐ Check if no allergies

Medication	Reaction or Side Effect

Immunizations: Please list your most recent immunizations and date received. **PLEASE BRING A COPY OF YOUR IMMUNIZATIONS TO YOUR FIRST APPOINTMENT.**

☐ Hepatitis A:	☐ Measles/Mumps/Rubella (MMR):	☐ Gardasil:
☐ Hepatitis B:	☐ Pneumovax (Pneumonia):	☐ Pertussis (Tdap):
☐ Tetanus Td:	☐ Varicella (Chicken Pox):	☐ Shingles
☐ Flu Vaccine:	Other:	Other:
☐ TB Skin Test:		