McPherson
CENTER FOR HEALTH

*Family Medicine*

David L. Buller, MD
Sheila W. Gorman, MD
John D. Mosier, DO
Dustie A. Samuels, DO
Gregory M. Thomas, MD
Carl E. Turner, DO
Trenton J. VanEaton, MD
Ruth Lehman Wiens, MD

Melisa Cooper, PA-C
Abigail Degan, DNP, APRN, NP-C
Tracy Sweat, PA-C
Nick Vogts, PA-C
Autumn Wilgers, NP-C, APRN

*General Surgery*

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

**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 family medicine physicians. If you have a request for a physician, 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
- Dustie A. Samuels, DO
- Greg M. Thomas, MD
- Carl E. Turner, DO
- Trenton J. VanEaton, MD
- Ruth Lehman Wiens, MD
- 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.

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Office Use Only

Date Patient Contacted_____ Date Received_____

*McPherson Medical and Surgical Associates*
*A department of McPherson Hospital*
*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 _____

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**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 _____

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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<br>Date: | | Last Mammogram Abnormal ☐ Yes ☐ No<br>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:<br>☐ DNR ☐Living Will ☐Power of Attorney<br>☐ Living Arrangements | Alcohol Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use<br>☐ Prior Use Quit Date: _____ |
| Caffeine Intake: ☐ Never ☐ Occasional ☐ Daily | Amount per week: _____ |
| Tobacco: ☐ Current – Type :_____ Freq: _____<br>☐ 2nd Hand ☐ Never ☐ Prior Use<br>Quit Date: _____ | Drug Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use<br>☐ Prior Use Quit Date: _____<br>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: | | |