



McPherson Medical and Surgical Associates
A department of McPherson Hospital, Inc.
1000 Hospital Drive, Medical Office Building
McPherson Kansas 67460
620-241-7400

General Surgery

OB/GYN

Family Medicine

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

Bret E. Heskett, MD, FACOG

David L. Buller, MD
Melisa Cooper, PA-C
Sheila W. Gorman, MD
Dan M. Lichty, MD
Jill Sigsbee, PA-C
Tracy Sweat, PA-C

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.

- o David Buller, MD
o Sheila Gorman, MD
o Dan Lichty, MD
o Greg Thomas, MD
o Carl Turner, DO
o Trenton VanEaton, MD
o Ruth Lehman Wiens, MD
o Autumn Wilgers, NP-C, APRN
o 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 \_\_\_\_\_



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.

ACKNOWLEDGMENT 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 \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name (Last, First MI)		Date of Birth	
Present Health Concerns:			
<b>Personal Medical History:</b> Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis).			
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Migraine Headaches	
Type:	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Stroke	
Date:	<input type="checkbox"/> Valvular (mitral/aortic)	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Concussion	<input type="checkbox"/> Rhythm (a-fib)	<input type="checkbox"/> Other	
<input type="checkbox"/> Depression	<input type="checkbox"/> Blockage (heart attack)		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other		
<input type="checkbox"/> Type I			
<input type="checkbox"/> Type II	<input type="checkbox"/> High Cholesterol		
<b>Surgical History:</b> (Please list all other prior operations and dates)			
<b>Operation</b>	<b>Date</b>	<b>Operation</b>	<b>Date</b>
<b>Procedure History:</b> (Please list all prior procedures and dates, i.e. Colonoscopy, Bone Density Scan, Heart Cath, Stress Test)			
<b>Procedure</b>	<b>Date</b>	<b>Procedure</b>	<b>Date</b>
<b>Women's Gynecological History:</b>			
# of Pregnancies	# of Deliveries	# of Abortions	# of Miscarriages
1 <sup>st</sup> day of most recent period	Age at 1 <sup>st</sup> period	Frequency of periods	Length of each
Last Pap Smear      Abnormal <input type="checkbox"/> Yes <input type="checkbox"/> No		Last Mammogram      Abnormal <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date:		Date:	

**PLEASE TURN OVER AND COMPLETE THE OTHER SIDE**

<b>Family History:</b>					
<b>Relative</b>	<b>Year of Birth</b>	<b>Age of Death</b>	<b>Cause of Death</b>	<b>Health Issues</b> (diabetes, high blood pressure, depression, cancer, etc.)	
Father					
Mother					
Siblings (Please circle one)					
Brother / Sister					
Brother / Sister					
Brother / Sister					
<b>Maternal</b> Grandmother / Grandfather					
<b>Paternal</b> Grandmother / Grandfather					
Other					
<b>Social History:</b>					
Occupation: _____			Marital Status (Circle One) Single / Married / Widowed / Divorced		
Advance Directives: <input type="checkbox"/> DNR <input type="checkbox"/> Living Will <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Living Arrangements			Alcohol Abuse: <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily <input type="checkbox"/> Prior Use		
Caffeine Intake: <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily			<input type="checkbox"/> Prior Use   Quit Date: _____ Amount per week: _____		
Tobacco: <input type="checkbox"/> Current – Type : _____ Freq: _____			Drug Abuse: <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily <input type="checkbox"/> Prior Use		
<input type="checkbox"/> 2 <sup>nd</sup> Hand <input type="checkbox"/> Never <input type="checkbox"/> Prior Use Quit Date: _____			<input type="checkbox"/> Prior Use   Quit Date: _____ History of Drug Abuse: _____		
<b>Medications:</b> Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs. If more space is needed you can attach a list. <b>BRING ALL OF YOUR MEDICATIONS TO YOUR FIRST APPOINTMENT.</b>					
<b>Medication</b>	<b>Dose</b>	<b>Times per day</b>	<b>Medication</b>	<b>Dose</b>	<b>Times per day</b>
<b>Allergies or Reactins to Medicines / Food / Other Agents:</b> <input type="checkbox"/> Check if no allergies					
<b>Medication</b>	<b>Reaction or Side Effect</b>				
<b>Immunizations:</b> Please list your most recent immunizations and date received. <b>PLEASE BRING A COPY OF YOUR IMMUNIZATIONS TO YOUR FIRST APPOINTMENT.</b>					
<input type="checkbox"/> Hepatitis A:		<input type="checkbox"/> Measles/Mumps/Rubella (MMR):		<input type="checkbox"/> Gardasil:	
<input type="checkbox"/> Hepatitis B:		<input type="checkbox"/> Pneumovax (Pneumonia):		<input type="checkbox"/> Pertussis (Tdap):	
<input type="checkbox"/> Tetanus Td:		<input type="checkbox"/> Varicella (Chicken Pox):		<input type="checkbox"/> Shingles	
<input type="checkbox"/> Flu Vaccine:		Other:		Other:	
<input type="checkbox"/> TB Skin Test:					