McPherson Medical and Surgical Associates
1000 Hospital Drive, Medical Office Building
McPherson, Kansas 67460
620-241-7400

General Surgery	Family Medicine		Walk In Clinic
Clayton D. Fetsch, MD, FACS Brandon J. Stringer, MD, FACS	Melisa Kieffer, PA-C Abigail Degan, DNP, NP-C, APRN Tracy Sweat, PA-C Grace Strella, MD Malia Sullivan, APRN Todd Stillson, MD, OB	Trenton J. VanEaton, MD Nicholas Vogts, PA-C Autumn Wilgers, NP-C, APRN Holly Burt, MD Bailee Norton, MD, OB	Shawna Johnson, DNP, AG-ACNP, APRN- Alyssa Hammond, APRN Stephanie Pena, FNP-C Eric Jusko, PA-C Rachel Stucky, PA

Patient Name:	**DOB:**

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 currently accepting new patients. If you have a preference on the provider, please denote that or simply highlight "no preference" and we will take care of the rest. We work hard to connect you with a provider that will meet your individual needs but cannot guarantee a specific provider's availability. we need this returned as soon as possible. ***Please fully fill out each page to the best of your abilities. Once you have completed filling out this new patient packet you can return it to the clinic front desk or via mail at the below address: If these packets are not returned at minimum 48-72 hours (about 3 days) prior to appointments, you may be contacted to reschedule.***

	Dr. Bailee Norton
	Dr. Holly Burt
	Abigail Degan, APRN
	Autumn Wilgers, APRN
	Melisa Kieffer, PA-C
	Nicholas Vogts, PA-C
	Tracy Sweat, PA-C
	Malia Sullivan, APRN
	No Preference

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, Patient Navigator Team

Office Use Only:	
Date Patient Contacted:	
Date Received:	
Appt Date/Time:	

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Patient Information

Name:		Sex:		Birthdate:	
Address:		Email:			
City:		State:		Zip:	
Primary Phone:		Secondary Phone:			
		Social Security:			
Patient Employer		Occupation:			
Business Address		Business Phone:			
Marital Status:	Single	Married	Separated	Divorced	Widowed

If Patient Is A Minor

Mother's Name:	DOB:	Phone:
Father's Name:	DOB:	Phone:

Insurance Infomration

Insured's Name:		Relation to Patient:			
Insured's Date of Birth:		Phone Number:			
Insured Employed By:		Employer Address:			
Insurance Company:				Member ID #	
Insurance Address:				Group #:	
Do you have additional Insurance?		Yes		No	**If yes, please complete the following:**
Insured's Name:		Relation to Patient:			
Insured's Date of Birth:					
Insured Employed By:		Employer Address:			
Insurance Company:				Group #:	
Insurance Address:				Member ID #	

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

Signature: **Relationship:** **Date:**

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

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Patient Medical History

Name:	**Date of Birth:**

Emergency Contacts: Please list name, date of birth, relationship and phone number.			
Name:	DOB:	Relationship:	Phone #:
Name:	DOB:	Relationship:	Phone #:
Name:	DOB:	Relationship:	Phone #:
Name:	DOB:	Relationship:	Phone #:

Please list your present health concern(s):

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	Migraine Headaches
Cancer Type: Date:	Heart Condition Valvular (mitral/aortic) Rhythm (a-fib) Blockage (heart attack) Other:	Diabetes Type: Date:
Concussion:		Condition
Depression:		High Cholesterol
Stroke	Anxiety:	Seizures:
High Blood Pressure	Other:	

Surgical History: Please list all other prior operations and dates.

Operations	Date

Procedure History: Please list all procedures and dates (Colonoscopy, bone scan, heart cath, stress test, etc.)

Women's Gynocolgical History

# of Pregnancies:	# of Deliveries:	# of Abortions:	# of Miscarriages:	Date of Last Pap Smear:
				Abnormal? yes no
Date of Last Perio	Age of 1st period	Length and Freq. of Periods		Date of Last Mammogram:
				Abnormal? yes no

Birth Control

Currently on birth control? **YES OR NO**	Do you wish to discuss birth control option with your provider? **YES OR NO**
Type of birth control you are taking? **ORAL CONTRACEPTIVE NEXPLANON IUD**	What type of birth control do you wish to discuss with your provider? **ORAL CONTRACEPTIVE PILL NEXPLANON IUD**

Family History				
Relative	Year of Birth	Age of Dea	Cause of Death	Health Issues
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brother				
Brother				
Sister				
Sister				
Other				

Social History

Advance Directives			
DNR?		yes	no
Living Will?		yes	no
Power of Attorney?		yes	no
Living Arrangements?		yes	no
Alcohol Abuse			
Never	Occassion	Daily	Prior Use
Amount Per Week:			
Quit Date:			
Drug Abuse			
Never	Occassion	Daily	Prior Use
Amount Per Week:			
Quit Date:			
Tobacco Abuse			
Never	Occassion	Daily	Prior Use
Type:			
Amount Per Week:			
Quit Date:			

Medications: Prescriptions and nonprescription medicines. Please list dosage and frequency. If more space is needed, please attach a list. Bring all the medication to your first appointment.

PHARMACY NAME AND LOCATION:_____

Allergies or Reactions to Food/Medication or Other Agents:	**Highlight if no allergies**	**none**

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Authorization for Use or Disclosure of Protected Health Information (PHI)

Instructions: Please complete the form in full. If any section is incomplete, this authorization will be considered invalid. Please print legibly. Use black or blue ink only. Do not use a pencil. **This is the release of Medical Records**

Section 1: Demographics

Patient Name:	Alias	Birthdate
Social Security #	Cell #	Work #:
Street Address:		

Section 2: Type of Access Requested

Please highlight the type of access you are requesting.

Paper Copy	Electronic Copy	Inspection of Record

Treatment Dates Requested:

Please describe the specific PHI you are requesting. *Highlight all that apply*

Abstract	Consult Report	Physician Report	Pathology Report
Face Sheet	Operative Report	Rehab Services	**Entire Record**
Emergency Room	Cardiac Services	Medication Record	Other:
History and Physical	Lab Reports	Nursing Notes	
Progress Notes	Imaging/Radiology Report	Discharge Summary	

I understand that the requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment of alcohol and drug abuse.

Section 3: Identifcation of Entity/Person/Class of Persons authorized to receive or release PHI

Release Information From:	Release Information To:
	Provider: _____ McPherson Center for Health 1000 Hospital Drive, Building 3 PH: 620-241-7400 Fax: 620-798-2631

Section 4: Expiration

Unless otherwise revoked, this authorization shall expire upon this date: _____ or no later than a year from the date on the authorization.

Section 5: Purpose for Disclosure

Please highlight one purpose or use.

Continued Care Litigation Personal Insurance/Dibability Other:

Section 6: Statements of Understanding

1. I understand that this authorization is voluntary and that I may refuse to sign it.
2. I understand that I may refuse to sign this authorization, and if I do not sign this form my health care or payment for health care will not be affected.
3. I understand that once the disclosure authorized herein has been made, the information disclosed may be subject to re-disclosure by any receipt and no longer protected by federal privacy laws.
4. I understand that I may revoke this authorization at any time by delivering a written revocation to the Health Information Management department of McPherson Hospital.
5. I understand that if I revoke this authorization, it will have no effect on disclosures already made in reliance on this authorization.
6. I authorize the use and disclosure of the protected health information, as described. I have received a copy of this form.

Name of Representive:

Signature:

Date:

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Permission to Disclose Information to those involved in my Care

Name:	DOB:

Patient Preferred Method of Contact	
Home Telephone #:	
Work Telephone #:	
Cell Phone #:	
Other:	

I hereby allow McPherson Medical and Surgical Associates to disclose the following protected health information:

Appointment Date and Time	Tests that have been received	Test Results

Other Health Information				
Permission to disclose information to the following people because they are involved with my healthcare or payment:				
Self	Name:		Phone #:	
Spouse	Name:		Phone #:	
Family Friend	Name:		Phone #:	
Child	Name:		Phone #:	
Child	Name:		Phone #:	
Child	Name:		Phone #:	
Parent or Guardian	Name:		Phone #:	
Other:	Name:		Phone #:	

I authorize McPherson Medical and Surgical Associates to furnish any information, reports or copies of records which may be requested by other doctors, hospitals, insurance companies, etc.

Signature:

Date: