



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 Aaron Holt, MD, OB Collin Harvey, MD,OB	Shawna Johnson, APRN Alyssa Hammond, APRN Eric Jusko, PA-C Rachel Stucky, PA Jake Perryman, APRN Kaylyn Best, APRN

Patient Name:	DOB:
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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, MD, OB
	Dr. Holly Burt MD
	Abigail Degan, APRN
	Autumn Wilgers, APRN
	Melisa Kieffer, PA-C
	Nicholas Vogts, PA-C
	Tracy Sweat, PA-C
	Malia Sullivan, APRN
	Dr. Aaron Holt, MD, OB
	Dr. Collin Harvey MD, OB
	No Preference

Start date 09/28/2026

Start date 09/28/2026

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:		
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 Information					
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?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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 #		
<p>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.</p>					
Signature:	Relationship:		Date:		
<p>Notice: Your health information related to work-related illnesses or injuries, or medical surveillance of the workplace may be disclosed to your employer.</p>					



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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	Heart Condition		Diabetes		
Type:	Valvular (mitral/aortic)		Type:		
Date:	Rhythm (a-fib)		Date:		
Concussion:	Blockage (heart attack)		Condition		
Depression:	Other:		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 Gynecological History					
# of Pregnancies:	# of Deliveries:	# of Abortions:	# of Miscarriages:	Date of Last Pap Smear:	
				Abnormal?	yes no
Date of Last Period:	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	What type of birth control do you wish to discuss with your provider?		ORAL
CONTRACEPTIVE NEXPLANON IUD		CONTRACEPTIVE PILL NEXPLANON IUD			

Family History				
Relative	Year of Birth	Age of Death	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: Identification 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 Representative:			
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:			