FALL GENERAL SURGERY, LLC

216 Third Street West, Suite 201 • Ashland, WI 54806
Hayward Office • 11128 N. State Hwy 77 & 27 • Hayward, WI 54843

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Patient Information

Last Name	First		Middle	Spouse's Name:
Sex (M/F) / Age	Date of Birth	Home Phone	Cell Phone	
Social Sec. #	Marital Status: Single Married Divorced Widowed Separated	Occupation	Employer	
Home Mailing Address		City	State	Zip
Employer Address		Work Phone	Can we call you at work? (yes/no)	
Name of friend or relative (not at same residence)		Phone		
Referring Doctor:	Primary Care Doctor/Clinic:	Address		

Responsible Party Information (if different than patient information)

Last Name	First	M.I.	Relationship to Patient	Home Phone	
Street Address **(if different from patient)**		City		State	Zip
Social Sec. #	Date of Birth	Occupation	Employer	Work Phone	
Employer Address			Can we call you at work?	Cell Phone	

Primary Insurance Information – Please provide copy of card.

Insurance Company Name & Address			Insurance Phone #
Policyholder (Insured's name)	Patient's relationship to policy holder		Insured's Employer
Insured's Date of Birth	Insured's Social Security #	Effective Date	Co-payment $

Secondary Insurance Information – Please provide copy of card.

Insurance Company Name & Address			Insurance Phone #
Policyholder (Insured's name)	Patient's relationship to policy holder		Insured's Employer
Insured's Date of Birth	Insured's Social Security #	Effective Date	Co-payment $

Medical History - Mark (X) symptoms and conditions you currently have or have had in the past.

Personal History
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart pacemaker
- ☐ Stroke
- ☐ Cancer
- ☐ Blood Clots
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Anemia
- ☐ Hemorrhoids
- ☐ Thyroid disease
- ☐ Bleeding tendency
- ☐ TB
- ☐ Diabetes
- ☐ Seizures
- ☐ Ulcers

General
- ☐ Loss of weight
- ☐ Loss of appetite
- ☐ Sweats
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach pain
- ☐ Heartburn
- ☐ Nausea or Vomiting
- ☐ Rectal Bleeding
- ☐ Abdominal pain

Urinary
- ☐ Burning on urination
- ☐ Frequent urination
- ☐ Blood in urine

Habits
- ☐ Smoker
- ☐ Former Smoker
- ☐ Alcohol consumer

Family History
- ☐ Heart disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Other Family History:

PREVIOUS SURGERIES	CURRENT MEDICATIONS

ALLERGIES	

Authorization to Pay & Release Medical Records

Our office will bill your insurance. You are responsible for the deductible, co-insurance, co-payment at time of visit, and any costs not covered by your insurance company. If you do not have insurance we would appreciate payment at the time of your visit. Our staff is available if you have any questions or concerns.

I authorize payment of medical benefits be made directly to Fall General Surgery, LLC for services rendered. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize use of information from this form to bill my insurance companies.

Signature of patient (or parent/guardian if patient is a minor) _____ Date _____

Rev. 03/05

Fall General Surgery, LLC
Summary Notice

I acknowledge that I have received from Fall General Surgery, LLC a written notice of Fall General Surgery, LLC's privacy practices for protected health information. I acknowledge that the written notice contains a description of how medical information about me may be used and disclosed and how I may access this information. I acknowledge that the notice also contains:

- A description of the types of uses and disclosures that Fall General Surgery, LLC is permitted to make for treatment, payment or health care operations with or without my written authorization
- A description of each of the other purposes for which Fall General Surgery, LLC is permitted or required to use or disclose protected health information without my written authorization
- A description of uses or disclosures that may be limited or prohibited by law
- The description contains sufficient detail to make me aware of the uses or disclosures that are permitted or required by the federal privacy rule and other applicable law
- A statement describing my individual rights with respect to my health information and a description of how I may exercise this right
- A statement describing the Fall General Surgery, LLC duties under the federal privacy law
- A statement describing how I may express concern to the Fall General Surgery, LLC and the Secretary of the Department of Health and Human Services if I believe my privacy rights have been violated
- I have received information explaining how to contact Fall General Surgery, LLC for further information and the effective date which the notice is first in effect

Signed_____ Date_____

Minor Patient Name_____

Please note that for us to release information to family members you must sign a release of information form; this does include spouses. Just ask the receptionist for the form OR designate below.

Please list below any people you would like to have access to your medical information on a regular basis, for example: your care-giver, spouse, brothers, sisters, moms, dads, sons, daughters, etc.

_____

Signed _____ Date _____

By signing above, I give unrestricted access to my medical records generated at FGS to the above named person(s).