FALL GENERAL SURGERY, LLC

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

George A. Fall, MD, FACS

James G. Nibler, MD

Patient Information

Last Name	First	Middle Initial

Sex ☐ M ☐ F	Age	Date of Birth	Home Phone	Cell Phone

Social Security Number	Email Address	How did you hear about Fall General Surgery?

Home Mailing Address	City	State	Zip

Spouse's Name	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed/Widower ☐ Separated

Race: ☐ White ☐ Black/African American ☐ Native American ☐ Asian ☐ Pacific Isl. ☐ Refused	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused	Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Russian ☐ Other:

Occupation	Employer

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

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 Security #	Date of Birth	Occupation	Employer	Work Phone

Employer Address	Can we call you at work? YES NO	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	ID#/Grp #

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	ID#/Grp #

Insured's Date of Birth	Insured's Social Security #	Effective Date	Co-payment $

Pt. Name: ____ **Date:**__________________________

Medical History - Mark (X) if you currently have or have had in the past:

Personal History
☐ High Blood Pressure
☐ Heart Attack
☐ Heart Pacemaker
☐ Stroke
☐ Cardiac stent/Bypass Surg.________________
☐ Cancer
Type:________________
☐ Blood Clots
☐ Kidney Disease
☐ Hepatitis
☐ Hernia
Type:________________
☐ Anemia
Type:________________
☐ Thyroid disease
☐ Bleeding tendency
☐ TB
☐ Diabetes
☐ Seizures
☐ Ulcers
Location:______________

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

Urinary
☐ Burning on urination
☐ Frequent urination
☐ Blood in urine
☐ Night time urination

Eyes/Ears/Nose/Throat
☐ Blurred vision
☐ Cross eyed
☐ Double vision
☐ Eye pain
☐ Earache
☐ Ear drainage
☐ Ringing in the ears
☐ Nosebleeds
☐ Runny nose
☐ Stuffy nose
☐ Postnasal drip
☐ Sinus problems
☐ Change in voice
☐ Difficulty swallowing
☐ Pain with swallowing

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

Musculoskeletal:
☐ Back pain
☐ Arthritis
☐ Gout
☐ Muscle weakness
☐ Muscle stiffness

Skin
☐ Easy bruising/Bleeding
☐ Change in moles
☐ Change in hair/nail texture
☐ Extreme dryness
☐ Hives
☐ Eczema
☐ Lumps or bumps
☐ Rashes

OB/Gyn History
☐ # Pregnancies:_____
☐ # Deliveries:_______
☐ Last Menstrual Period:__________________

Lung problems
☐ Asthma/wheezing
☐ Bronchitis/pneumonia
☐ Dry cough.
☐ Productive cough
☐ Cough up blood
☐ Shortness of breath
☐ Oxygen use

Immunizations:
☐ Up to date ☐ Influenza
☐ Tetanus ☐ Pneumonia

Habits
☐ Smoker:
☐ Former Smoker:
☐ Alcohol:
glasses/wk:__________
☐ Exercise:____________
____

Heart
☐ Heart palpitations
☐ Chest pain
☐ Sleep with two or more pillows
☐ Poor circulation
☐ Swelling of ankles or legs
☐ Varicose veins
☐ Cholesterol
☐ CHF

Psychiatric
☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Memory loss
☐ Forgetfulness
☐ Loss of sleep
☐ Nervousness
☐ Irritability.

Neurological
☐ Headache
☐ Dizziness
☐ Fainting
☐ Difficulty speaking
☐ Loss of coordination
☐ Loss of sensation
☐ Numbness
☐ Seizures
☐ Senility
☐ Tremors
☐ Sciatica

Screening History
MALE:
☐ Prostate/PSA
Date:______________
FEMALE:
☐ Mammogram
Date:______________
☐ Pap smear
Date:______________
ALL:
☐ Colonoscopy:
Date:______________

Family History
☐ Parents still living
☐ Mother died
age:________________
of_________________
☐ Father died
age:________________
of_________________
☐ Heart disease
Who:______________
☐ Cancer
Who______________
Type:_____________
☐ Diabetes
Who:______________
☐ Anesthesia problems:
☐ Bleeding or Clotting Disorder:___________
☐ Other Family History:

Previous Surgery/Hospitalization	Approximate Date/Facility

Current Medications – Preferred Pharmacy:_______________________________________

Medication	Dose	Frequency

Allergies

Medication	Reaction

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

Please note that for us to release copies of your medical records to family members you must sign a release form; *this includes spouses*. Just ask the receptionist for the form.

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.

____

Patient Signature____Date_______________________

Minor Patient Name________________________________

By signing above, I allow Fall General Surgery and its staff members to relate information regarding my care to the above named person(s). I understand that this is effective for one (1) year from the date of my signature and does not grant access to my medical record.

Authorization to Pay & Release Medical Records

Our office will bill your insurance. It is your responsibility to understand your insurance plan and coverage details. 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 require payment at the time of your visit. Our staff is available if you have any questions or concerns. Fall General Surgery reserves the right to withhold overpayment refunds less than or equal to $5.00.

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 dependent'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**