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	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:

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	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 $

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 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 _____

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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