

Colonoscopy Packet

- **This packet contains forms for Kitsap General Surgery. It includes;**
 1. Registration forms for Kitsap General Surgery.
 2. A map to The Surgery Center of Silverdale, which is located in the Clear Creek Medical Building

Please fill out the registration and medical history forms, and mail them to:

**Kitsap General Surgery
9927 Mickelberry Road NW Suite 121
Silverdale, WA 98383**

As soon as we receive the forms back the doctor will review them. We will then call you to schedule the colonoscopy. At that time we will go over the bowel prep instructions and a prescription for the bowel prep will be sent to the pharmacy of your choice.

NOTE: Please be sure to fill out all 4 of the registration forms. If you send them back incomplete, we will not be able to schedule your colonoscopy.

PLEASE NOTE:

The colonoscopy will be performed at **The Surgery Center of Silverdale**. They also have separate registration forms that you will need to fill out. You may pick them up at our office prior to your procedure, or if you prefer, you can find them on the Surgery Centers website at www.silverdaleasc.com. They can also just be filled out at The Surgery Center of Silverdale on the morning of your procedure.

If you have any questions regarding the forms, please call our office.

Phone (360) 613-1335

Fax (360) 613-1329

9927 MICKELBERRY ROAD, SUITE 121
SILVERDALE, WASHINGTON 98383
TELEPHONE (360) 613-1335
FAX (360) 613-1329

KITSAP GENERAL SURGERY, PLLC

G. GREGORY FLEISCHHAUER, M.D., F.A.C.S.
TY CHUN, M.D., F.A.C.S.
THOMAS A. WIXTED, M.D.

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

DOB: _____ SS#: _____ Gender: M F Marital Status: M S W

Race: _____ Ethnicity: _____ Preferred Language: _____

Referring Dr: _____ Family Dr. _____

Preferred Pharmacy: _____ Location: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Person Responsible for Bill: _____

Address if different from above: _____

Primary Ins: _____	Secondary Ins: _____
Group No: _____	Group No: _____
ID No: _____	ID No: _____
Subscribers Name: _____	Subscriber's Name: _____
Subscriber's DOB: _____	Subscriber's DOB: _____

I acknowledge that this information provided to Kitsap General Surgery is accurate and current.

Signed: _____ Date: _____

Financial Policy, Assignment Information, and Release of Information

I authorize release of any information acquired in the course of treatment necessary to complete and file medical claims to my insurance company or Medicare on my behalf. I hereby acknowledge financial responsibility for cost of services rendered for me or for the person whose account I am acting as guarantor. I authorize (assign) any insurance or Medicare benefits to be paid directly to Kitsap General Surgery, PLLC or its assignees. I am responsible for any non-covered services, supplies, co-payments or deductibles. I am responsible for knowing how my plan works when I request medical services at this office. This acceptance and assignment will be in force all future services by practitioners from this office.

Signature of Patient or Patient's guardian/representative

Date

Printed name of person signing above

Acknowledgement of Notice of Privacy Practices

I understand that as part of my health care, Kitsap General Surgery originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality.

I understand that Kitsap General Surgery maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this Notice is available upon request. I understand that Kitsap General Surgery reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional written copy of this Notice at any time. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had an opportunity to receive and review the *Notice of Privacy Practices* of Kitsap General Surgery.

Signature of Patient or Patients guardian/representative

Date

Printed name of person signing above

Release of Medical Information

Please list the individuals you wish for us to communicate with regarding your care.

Name of Individual	Relation	Phone Number

HEMATOLOGY

Easy Bleeding No Yes
Bruising No Yes
Swollen Glands No Yes
Varicose Veins No Yes

NEUROLOGY

Headache No Yes
Tingling/Numbness No Yes
Seizures No Yes
Memory Loss No Yes
Dizziness No Yes
Gait Abnormalities No Yes

ENDOCRINOLOGY

Fatigue No Yes
Excessive Sweating No Yes
Excessive Thirst No Yes
Excessive Urination No Yes
Cold Intolerance No Yes
Heat Intolerance No Yes

CONSTITUTIONAL

Weight Change No Yes
Loss of Appetite No Yes
Fever No Yes
Weakness No Yes
Bleeding Problems No Yes
Fatigue No Yes

ENT/RESPIRATORY

Shortness of Breath No Yes
Cough No Yes
Nose Bleeds No Yes
Hearing Loss No Yes
Change in Voice No Yes
Sore Throat No Yes
Ringing in Ears No Yes
Sinus Pain No Yes

CARDIOLOGY

Leg Swelling No Yes
Chest Pain No Yes
Murmurs No Yes
Palpitations No Yes
Dizziness No Yes

GASTROENTEROLOGY

Nausea No Yes
Heartburn No Yes
Vomiting No Yes
Difficulty Swallowing No Yes
Abdominal Pain No Yes
Diarrhea No Yes
Constipation No Yes
Change in bowel habit No Yes
Blood in Stool No Yes
Estimate the month and year of your last colonoscopy _____

MUSCULOSKELETAL

Neck Pain No Yes
Back Pain No Yes
Joint Stiffness No Yes
Joint Pain No Yes
Joint Swelling No Yes
Leg Cramps No Yes

PSYCHOLOGICAL

Depression No Yes
Tension/Stress No Yes
Sleep Disturbances No Yes
Suicidal Ideation No Yes
ADHD No Yes
Eating Disorder No Yes
Anxiety No Yes

GENTOURINARY:

MALE

Difficulty Urinating No Yes
Increased Urinary No Yes
Hernia No Yes
Undescended Testicle No Yes
Kidney Disease No Yes
Hard Testicle No Yes
Hypospadias No Yes
Retractile Testicle No Yes

GENTOURINARY:

FEMALE

Heavy Periods No Yes
Difficulty Urinating No Yes
Increased Urinary No Yes
Pelvic Pain No Yes
Vaginal Discharge No Yes
Hot Flashes No Yes
Estimate the month and year of your last mammogram _____

Family History of Cancers:

	Age	List History and Type of Cancer	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling's	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

OFFICE USE ONLY

MA _____
MD _____

PATIENT NAME: _____

PLEASE STATE YOUR MAIN REASON FOR SEEING THE DOCTOR TODAY:

PAST MEDICAL HISTORY

**Previous Surgeries or
Hospitalizations:**

**Chronic Medical
Illnesses:**

Current medications: None

Allergies: No known Allergies

SOCIAL HISTORY

Smoking: Never

Current Smoker: Some Day Smoker Every Day Smoker

Packs Per Day: _____ Number of years: _____

Former Smoker: Year Stopped: _____ Number of years you smoked: _____

Alcohol: Never Occasional Moderate Heavy

Alcohol Problem: Yes No

Notice of Privacy Practices

Effective Date: April 14, 2003

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health safety
- As required by the Military or Veteran and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you

- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (full Notice is available upon request)

Changes to this Notices:

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator to file a complaint.

Acknowledgement of Receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of you records.

Map and Directions



surgerycenter
of SILVERDALE, LLC

9800 Levin Road NW
Suite 102
Silverdale, WA 98383
(360) 692-2728

From Bainbridge Island, Kingston, Poulsbo and other points north of Silverdale:

Take Highway 3 South to the Kitsap Mall **Exit 45**. Turn right at the end of the ramp on to Kitsap Mall Boulevard. Continue straight through the intersection with Silverdale Way, to Levin Road NW. Turn right onto Levin Road. We are the first building on the left side of Levin. The driveway is past the building on the left. Drive around to the front of the building.

From Bremerton, Port Orchard, Tacoma and other points south of Silverdale:

Take Highway 3 North to the Clearcreek Road/Kitsap Mall **Exit 45A**. Turn right at the end of the ramp on to Kitsap Mall Boulevard. Continue straight through the intersection with Silverdale Way, to Levin Road NW. Turn right onto Levin Road. We are the first building on the left side of Levin. The driveway is past the building on the left. Drive around to the front of the building.

