

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

**GENITOURINARY:**

**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

**GENITOURINARY:**

**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.

---