KITSAP GENERAL SURGERY

Last Name: ________________________ First Name: ____________________________ MI:____

Mailing Address:____

City:______________________________State:_________________Zip:_____________________

Residential Address: ____

Home Phone:_________________ Cell: ____________________ Work: ______________________

Email Address:
____

DOB:_________________ SS#: ________________ Gender: M F Marital Status: M S W

Race: _______________ Are you Hispanic or Latino: Yes No Language: ________________

Referring Dr: _______________________ Family Dr. ______________________________

Preferred Pharmacy: __________________________ Location: _________________________

Emergency Contact:___________________ Phone:________________ Relationship:____________

Person Responsible for Bill:____

Address if different from above: ____
How would you like to be notified for preventative care management: (ie: Colonoscopy/Mammo recall) Phone call Letter Emessage through Patient Portal (you must provide us w/ your email)

Primary Ins:__________________________ **Secondary Ins:**_________________________________

Group No: _______________________________ GroupNo:____________________________________

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:**_____________________

PLEASE TURN OVER

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 herby 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. By providing my cell, landline, or any other number (s), I expressly consent to receiving communications from the provider (s), its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by a live agent, voicemail, text message, using an auto-dialer or other computer assisted technology, pre-recorded message (s), or by any other form of electronic communication, including email at any email address I provide, for any purpose.

____ ___________________________

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.

Kitsap General Surgery has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health information, and whom to contact if you have any questions, concerns, or complaints. We may change the Notice of Privacy Practices at any time. You may obtain a current copy of the Notice of Privacy Practices or ask questions at anytime.

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 allow us to communicate with regarding your care.

____

Name of Individual ***Relation*** ***Phone Number***

____

Name of Individual ***Relation*** ***Phone Number***

*****FOR OFFICE USE ONLY*****

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:
Date__________________ Staff initials________________Reasons:____

PATIENT NAME: ____

How did you hear about us?
□ Online □ Friend/Relative □ ER/Hospital Referral □ Physician__________________

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

____

____

____

____

Are you currently taking medication to treat high blood pressure: NO YES

Who is your cardiologist?
____

SOCIAL HISTORY

Smoking: Never
Current Smoker: ☐Some Day Smoker ☐ Every Day Smoker
Cigarettes smoked per day: _______ Number of years: _______
Former Smoker: Year stopped: ______ Number of yrs you smoked:_____

Alcohol: How often did you drink alcohol in the past yr? ☐Never ☐ Monthly or less
☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week
How many drinks do you have on a typical day when you are drinking? ______
How often did you have 6 or more drinks on one occasion in the past yr?
Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

PLEASE TURN OVER

CONSTITUTIONAL

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

HEMATOLOGY

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

	Diabetic	High blood pressure	Heart disease	Stroke	Cancer	Unknown
Father: Alive or Deceased Age____	Yes No	Yes No	Yes No	Yes No	Yes No	_____
Mother: Alive or Deceased Age____	Yes No	Yes No	Yes No	Yes No	Yes No	_____
Siblings: Alive or Deceased Age____	Yes No	Yes No	Yes No	Yes No	Yes No	_____
Children: Alive or Deceased Age___	Yes No	Yes No	Yes No	Yes No	Yes No	____