Allegan General Surgery

551 Linn Street, Ste. 247 • Allegan, MI • 49010

Date: ____________________ (for office use only) Account Number: ________________
Name: ____ Date of Birth: _____________
Address: _____________________________________ City: __________________ State: _______
Zip: ___________ Social Security #: ______________ Driver's License #: ___________________

Home Phone: _______________ Cell Phone: ________________ Work Phone: ________________
Email: _________________________________ Best Method of Communication: ______________
Marital Status: __________________Employer: ____

Primary Care Doctor: ______________________ Referring Provider: ________________________
Pharmacy Name: _____________________________________ Phone Number: ________________
Pharmacy Address: ____

If patient is a minor or full time student, please complete the following: (if different from above)
Parent's Name: ____________________________________ Date of Birth: ___________________
Address: _____________________________________ City: __________________ State: _______
Zip: _______________ Home Phone: ___________________ Cell Phone: ___________________
Employer: ____________________________________ Social Security #: ____________________

Emergency Contacts:
Name: ___________________________ Phone: ________________ Relationship: _____________
Name: ___________________________ Phone: ________________ Relationship: _____________

US Government Reporting:
I would prefer not to disclose this information. ☐
Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Type Unknown
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Type Unknown
Language: ☐ English ☐ Spanish ☐ Chinese ☐ French ☐ Japanese

I agree Allegan General Surgery may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Signature: ____ Date: ___________________

FOR OFFICE USE ONLY:
Reviewed by: ____ Date: ___________________

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Patient Name: ____Date of Birth: ________________

Review of Systems: Are you (or the child) currently having or have you had problems with your (check boxes that are positive and explain if necessary):

☐	Fatigue	☐	Irregular heartbeat	☐	Anemia
☐	Fever	☐	Heart murmurs	☐	Bleeding problems
☐	Weight Loss	☐	Nausea	☐	Numbness or Tingling
☐	Headache	☐	Vomiting	☐	Dizziness
☐	Blurred Vision	☐	Constipation	☐	Headaches
☐	Corrective Lenses	☐	Diarrhea	☐	Rashes
☐	Congestion	☐	Incontinence	☐	Skin disorders
☐	Hearing loss	☐	UTI	☐	Connective Tissue disorder
☐	Jaw discomfort	☐	Difficulty urinating	☐	Change in mood/behavior
☐	Shortness of breath	☐	Diabetes	☐	Change in sleep patterns
☐	Wheezing	☐	Thyroid problems	☐	Asthma
☐	Cough	☐	Growth delays	☐	Communicable diseases
☐	Chest pain	☐	Joint pain	☐	Hay fever
☐	HIV	☐	Hepatitis A, B, or C	☐	Other ___________________

Allergies: ____

Past Surgeries:

____

____

Medications:

____

____

Height: ____________________ Weight: _____________________

Have you ever had general anesthesia? ☐ No ☐ Yes

Have you had any problems with general anesthesia? ☐ No ☐ Yes

If yes, please describe: ____

Have you had any problems with bleeding? ☐ No ☐ Yes

If yes, please describe: ____

Patient Name: ____ Date of Birth: ____________

PRIVACY RIGHTS

We appreciate the trust that you have placed in us, and one of the ways that we will protect that trust is by respecting the privacy of all our patients. We are required by federal and state law to maintain the privacy of your health information. Federal and state laws allow us to use your health information for treatment, payment and for other limited uses. We cannot use or disclose your health information for any reason not allowed by law unless you give us written permission.

In general, the privacy law gives you the right to request a restriction on the use and disclosure of your Protected Health Information (PHI). The law does not allow us to speak to a member of your family, another relative, or a close friend who may be involved in your care unless you request in writing that we do so. A complete description of our privacy notice is on display on our website of www.allegansurgery.com or available from our receptionist.

I authorize Allegan General Surgery to disclose Protected Health Information for appointment or other healthcare purposes to the following people: If you don't want to list anyone please circle: NONE

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Please note if you do not provide the correct insurance information, it may be possible you will be responsible for all charges that are incurred during your visit and treatment here. Correct insurance information is very important as we use this information to obtain important authorizations for your treatment and care here. If we are unable to get authorization for your treatment here due to the lack of correct insurance information, you will responsible for complete charges. I have read and accept the terms of agreement of Allegan General Surgery's financial policy.

Please sign below stating that you understand and accept the above statement.

Signature: ______________________________________ Date: ________________