CASPER GENERAL SURGERY
Lane L. Smothers, M.D. F.A.C.S. / Laura Smothers, M.D. F.A.C.O.G.
1540 Centennial Ct, Suite 300, Casper, WY 82609
307.337.4981 | 307.337.4984 (fax)

PATIENT INFORMATION

Date: ____/____/____ Referring provider _____ Primary Care provider _____

Patient's Legal Name: _____ Nickname: _____

Age: _____ Birth Date: ____/____/_____ Gender: M F

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

RESPONSIBLE PARTY (GUARANTOR)

(IF OTHER THAN PATIENT, PLEASE FILL IN BELOW)

Name & Relationship: _____ Phone Number: _____

Mailing Address: _____

City, State, Zip Code: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone #: _____

CARD ON FILE ☐

PRIMARY INSURANCE

Insurance: _____ ID/Policy #: _____ Group #: _____

Claims Address: _____

Policy Holder: _____ **Date of Birth**: ____/____/_____ Relationship: _____

CARD ON FILE ☐

SUPPLEMENTAL INSURANCE

Insurance: _____ ID/Policy #: _____ Group #: _____

Claims Address: _____

Policy Holder: _____ **Date of Birth**: ____/____/_____ Relationship: _____

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AUTHORIZATION AND FINANCIAL UNDERSTANDING

By accepting the medical services provided to me by Lane L. Smothers, MD and/or any other employee of corporation, I agree to be financially responsible for the charges billed by Casper General Surgery.

- If medical insurance covers all or a portion of the charges I incur by Lane L. Smothers and/or any other employee of the corporation for my treatment, I hereby assign those insurance benefits to Casper General Surgery & authorize the insurance benefits to be paid directly to Casper General Surgery. This assignment will remain in effect until revoked by me in writing.
- I understand and agree that if my insurance benefits do not cover all of the charges for my treatment, including what my insurance company classifies as over reasonable and customary charges, I am responsible to pay any outstanding balances. I further agree that in the event of a non-payment to Casper General Surgery or any amounts due under this agreement I will pay interest thereon at the rate of 1.75% per month and pay all of Casper General Surgery reasonable legal fees & court costs that may be incurred. I agree that in the event that this agreement is assigned to a collection agency for collection, I promise to pay a collection fee of up to 50% of the unpaid balance due, in addition to the unpaid balance due under this agreement. Furthermore, the jurisdiction of this note shall be in Natrona County, Wyoming if suit is brought hereon.
- I understand that it may be necessary for Casper General Surgery to disclose medical information about my treatment to my insurance company(s), employer, or third-party payer in order to process a claim on my behalf.
- A photocopy of this assignment and financial agreement is considered to be as valid as an original.
- I understand that it is my responsibility to contact my insurance company for pre-notification.

Patient / Guardian signature: _____ **Date:** ____/____/_____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (patient) give permission to Casper General Surgery to discuss and/or release my medical and/or billing information to the following persons if they were to call or come into the office on my behalf:

	NAME	RELATIONSHIP	PERMISSION TO SHARE
1.	_____	_____	□ **Medical Info** □ **Billing info**
2.	_____	_____	□ **Medical Info** □ **Billing info**
3.	_____	_____	□ **Medical Info** □ **Billing info**

- **Duration:** This authorization shall become effective immediately and shall remain in effect until revoked.
- **Right to terminate/revoke:** Authorization may be revoked or terminated in writing to Casper General Surgery.
- **Potential for re-disclosure:** Information disclosed may be disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

___ Yes consent to leave medical information via voicemail on my secure phone – (____) _____-_____
___ No please do not leave medical information regarding normal test results on my voicemail

Patient / Guardian signature: _____ **Date:** ____/____/_____

HIPAA NOTICE OF PRIVACY PRACTICES

By signing below, I am solely giving acknowledgement that I have received or have been given opportunity to receive a copy of Casper General Surgery HIPAA Notice of Privacy Practices.

Patient / Guardian signature: _____ **Date:** ____/____/_____

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Patient's Name: _____ Date of Birth: ____ / ____ / _____

HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT: _____

1. How long have you had this problem? _____
2. What makes your problem worse? _____
3. What makes your problem better? _____
4. Have you been treated for this before? _____

ALLERGIES **NONE** (circle if none) **REACTION**

_____ _____
_____ _____
_____ _____

MEDICATIONS **NONE** (circle if none) **SEE LIST** (circle if you brought a separate list)

Medication Name	Dose	Frequency

Local Pharmacy: _____

Are you currently taking blood thinners? NO YES _____ Last INR: ____ / ____ / ____

Do you have a pain contract? NO YES Provider: _____

Patient / Guardian Signature: _____ **Date:** _____ / _____ / _____

PAST MEDICAL HISTORY *CIRCLE ALL CONDITIONS THAT APPLY*

Respiratory disease Heart disease Thyroid disease Kidney disease Cancer Diabetes

Other medical conditions: _____

PAST SURGICAL HISTORY

Surgery **NONE** (circle if none)	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Father Living Deceased Cause of death? _____

Mother Living Deceased Cause of death? _____

Family History of: (Circle those that apply)

Diabetes Hypertension Heart disease Arthritis High cholesterol Cancer: _____

Other family medical history: _____

SOCIAL HISTORY

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to specify

Race: White Black or African Am Asian Am Indian or Alaska Native

Native Hawaiian or other Pacific Islander Decline to specify

Marital status: Married Single Divorced Widowed

Tobacco: ___ Never

___ Former Quit: _____ Packs/day: _____ Number of years: _____

___ Current Packs/day: _____ Years: _____ Interested in cessation: No Not now Yes

Smokeless tobacco: No Yes quantity: _____ Interested in cessation: No Not now Yes

Alcohol: No Yes Type: _____ Quantity: _____ Frequency: _____

Illicit Drugs: No Yes Type: _____ Frequency: _____

REVIEW OF SYSTEMS

Circle all that apply

GENERAL: Fever Chills Night sweats Headache Weight gain Weight loss Decreased appetite

EYES: Glasses Contacts Glaucoma Macular Degeneration Vision loss Vision changes

ENT: Decreased hearing Hearing loss Ringing Nasal drainage Congestion Recent sinus infection Sore throat Voice changes Hoarseness Loose teeth

RESP: Cough Exercise intolerance Shortness of breath Asthma COPD Emphysema Snoring Sleep apnea CPAP Oxygen

CARDIO: Chest pain Palpitations MI A-fib Murmur Pacemaker AICD

GI: Nausea Vomiting Stool changes Heartburn Dysphagia Food intolerance Abdominal pain Liver disease Gastroparesis Hemorrhoids

GU: Frequency Urgency Incontinence Retention Hematuria Dysuria Kidney stones BPH

MUSCULOSKELETAL: Neck pain Back pain Joint pain Limited range of motion metal implants

NEURO: Seizure Stroke Altered sensation Memory issues

SKIN: Rash Lesions Easy bruising

BREAST: Pain Lumps Nipple retraction Nipple discharge Skin changes Implants

HEME/LYMPHATIC: Bleeding/clotting disorders DVT PE Blood transfusion Lymph node enlargement

ALLERGIC/IMMUNOLOGIC: Seasonal allergies Autoimmune disease MRSA

ENDOCRINE: Diabetes Hypothyroidism Hyperthyroidism Hashimoto's

PSYCH: Anxiety Depression Bipolar disorder

Other medical issues: _____