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: ______________

Email Address: ____

Preferred Pharmacy: ____

EMERGENCY CONTACT

Name: ______________________ Relationship: ____________________ Phone #: ______________

RESPONSIBLE PARTY (GUARANTOR)

(IF OTHER THAN PATIENT, PLEASE FILL IN BELOW)

Name & Relationship: ____________________________________Phone Number: ______________

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 Laura C 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:** ___/___/____

NAME: ______________________ **DATE:** ____ / ____ / ____

OCCUPATION: ______________________ **MARITAL STATUS:** __________

REASON FOR VISIT: ______________________

PAST GYNECOLOGIC PROBLEMS: (including abnormal pap smears)

____

____

____

PAST/CURRENT MEDICAL PROBLEMS: (anything requiring medication, treatment or hospitalization)

____

____

____

PRIOR SURGERIES AND DATES:

Surgery	Date	Surgery	Date

PREGNANCY HISTORY: **# OF PREGNANCIES:** ____ **# of Adopted/Foster Children** ____

(birth, miscarriage, etc) (birth, miscarriage, etc)

Pregnancy Date: ________ Outcome: __________ Pregnancy Date: ________ Outcome: __________

Pregnancy Date: ________ Outcome: __________ Pregnancy Date: ________ Outcome: __________

LIST YOUR CURRENT METHODS OF PREGNANCY PREVENTION: ______________________

(or circle one of the following)

Abstinence *Menopause* *Female partner* *I want pregnancy*

CHECK HERE IF YOU ARE INTERESTED IN STARTING OR CHANGING BIRTH CONTROL: ____

DRUG ALLERGIES OR REACTIONS: ____ Yes ____ No **If YES, please describe below:**

Drug: __________ Reaction: __________ Drug: __________ Reaction: __________

LIST OF MEDICATIONS and DOSAGES: ** **If extensive, provide list to office staff to copy****

Medication	Dose	Medication	Dose

FAMILY HISTORY: List blood relatives affected by cancer, genetic disease, disorders of blood clotting, high blood pressure, diabetes, heart disease or anything else you feel is important.

____

____

____

TOBACCO: __Never __ Former__ Current -Amount ________ **VAPE:** __ No __ Yes -Amount: ________

ALCOHOL: __ No __ Yes - Amount: ________

HISTORY OF ALCOHOLISM/ADDICTION: ___ No ___Yes Last Use: ________

NOTE: Please tell the doctor all your concerns before the physical exam.

If you need testing for sexually transmitted diseases, please tell the doctor