

PATIENT INFORMATION (PLEASE PRINT)



SOC SEC #: _____ - _____ - _____

MRN#: _____

Name: _____
Last First Mid Initial

Home Phone: _____

Work Phone: _____ Ext: _____

Address: _____

Cell Phone: _____

City: _____

Date of Birth: _____ - _____ - _____ Age: _____ yrs

State: _____ Zip Code: _____

Employer: _____

SEX: Male Female

Work Address: _____

MARITAL STATUS: Married Single Divorced
 Partner Widowed Separated

City: _____ State: _____ Zip: _____

Occupation: _____

PRIMARY CARE PHYSICIAN: _____

Email: _____ @ _____

REFERRAL

Who referred you to our clinic? (**PLEASE CHECK BOX**)

- | | | |
|---|---|---|
| <input type="checkbox"/> Washington Regional Medical Center | <input type="checkbox"/> Community or Company Health Fair | <input type="checkbox"/> Referred by a Physician: _____ |
| <input type="checkbox"/> Newspaper or Magazine | <input type="checkbox"/> Treated by Physician in hospital | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Recommended by friend or family member | <input type="checkbox"/> Internet | <input type="checkbox"/> Insurance Plan Directory |
| <input type="checkbox"/> Drove by Location of Clinic | <input type="checkbox"/> Phone Directory (Yellow pages) | <input type="checkbox"/> Return Patient/ Not Applicable |
| | | <input type="checkbox"/> Other: _____ |

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____

Cell: _____

Employer: _____

Work: _____ Ext: _____

Work Address: _____

Spouse/Parent SEX: Male Female

City: _____ State: _____ Zip: _____

Spouse/Parent Date of Birth: ____ / ____ / ____

Occupation: _____

Social Sec. #: _____ - _____ - _____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____

Cell Phone: _____

Address: _____

Home Phone: _____

State: _____ Zip: _____

GENERAL INFORMATION

Who is responsible for Payment?: Myself Other: _____ (FILL OUT BELOW)

Responsible Party Name: _____ Responsible Party DOB: ____/____/____

Relationship to Patient: Self Spouse Child OTHER SS# _____ - _____ - _____

Address: _____ Phone#: _____

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? Yes No

If Yes, When?: ____/____/____ Where?: _____

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Preferred Language: English Spanish Marshallese Arabic DECLINE OTHER: _____

Race: White African American Asian Native Hawaiian/Other Pacific Islander

Native American Indian/ Alaskan Hispanic Unknown DECLINE

Ethnicity (Origin): Not Hispanic or Latino Hispanic or Latino Unknown DECLINE

Preferred Communication Method: Print Save to Flash Drive DECLINE

Wellness Reminders: Mail Cell Phone Home phone Work Phone DECLINE

PREFERRED PHARMACY: _____ **LOCATION:** _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X _____
Signature (Patient or Parent/Guardian if minor)

Date: ____/____/____



507 W. Monroe Ave. - Suite A
Lowell, AR 72745 ■ 479-463-8150 ■ 479-463-8151 (fax)

Past Medical History

| | |
|--|--|
| | |
| | |
| | |
| | |

Surgical History

| | |
|--|--|
| | |
| | |
| | |
| | |

Current Medications

| Medication Name | Dosage | Frequency |
|-----------------|--------|-----------|
| | | |
| | | |
| | | |
| | | |

Allergies

| | |
|--|--|
| | |
| | |

Family History (ie: Diabetes, Heart Disease, Hypertension, Cancer)

| | |
|-----------------------|--|
| Mother: | |
| Father: | |
| Siblings: | |
| Maternal Grandmother: | |
| Maternal Grandfather: | |
| Paternal Grandmother: | |
| Paternal Grandfather: | |
| Other: | |

REVIEW OF SYSTEMS

(please mark all that apply)

Patient Name: _____ Date: _____

ATTENTION FEMALES: Are you pregnant or think you may be pregnant? YES _____ NO _____

Have you seen another doctor since your last visit with us? YES _____ NO _____

| | | |
|---------------------------------|---|---|
| <u>Constitutional</u> | Y | N |
| Chills | | |
| Fatigue | | |
| Fever | | |
| Feeling Weak | | |
| Recent Weight Gain (_____ lbs) | | |
| Recent Weight Loss (_____ lbs) | | |
| <u>HEENT</u> | Y | N |
| Vision Loss | | |
| Seeing Double | | |
| Blurred Vision | | |
| Ear Pain | | |
| Hearing Loss | | |
| Sinus Pressure | | |
| Runny Nose | | |
| Sneezing | | |
| Sore Throat | | |
| <u>Respiratory</u> | Y | N |
| Cough | | |
| Shortness of Breath | | |
| Wheezing | | |
| <u>Cardiovascular</u> | Y | N |
| Chest Pain | | |
| Palpitations | | |
| Swelling | | |
| <u>Skin</u> | Y | N |
| Rash | | |
| Lesion | | |
| Itching | | |
| Bruise Easily | | |
| <u>Gastrointestinal</u> | Y | N |
| Abdominal Pain | | |
| Blood in Stool | | |
| Heartburn | | |
| Constipation | | |
| Lack of Appetite | | |
| Diarrhea | | |
| Nausea | | |
| Vomiting | | |
| <u>Genitourinary</u> | Y | N |
| Painful Urination | | |
| Blood in Urine | | |
| Frequent Urination | | |
| Urinary Incontinence | | |
| Bladder Spams | | |

| | | |
|---|-------|---|
| Urinary Stream is decreased | | |
| <i>Females: Last Menstrual Period</i> | Date: | |
| Females: Irregular Periods | | |
| Females: Vaginal Discharge | | |
| Females: Breast Lump | | |
| Females: Nipple Discharge | | |
| Males: Erectile Dysfunction | | |
| Males: Penile Discharge | | |
| <u>Musculoskeletal</u> | Y | N |
| Back Pain | | |
| Neck Pain | | |
| Joint Pain | | |
| Joint Swelling | | |
| Muscle Weakness | | |
| <u>Neurological</u> | Y | N |
| Dizziness | | |
| Difficulty Walking | | |
| Headache | | |
| Memory Loss | | |
| Numbness in Extremities | | |
| Tremor | | |
| Seizures | | |
| <u>Psychiatric</u> | Y | N |
| Anxiety | | |
| Insomnia | | |
| Depression | | |
| <u>Other Problems:</u> | | |
| <u>Social History:</u> | | |
| Do you use tobacco products? Y or N | | |
| Do you drink alcohol? Y or N. How much per day? | | |

ATTENTION New Patients:

How did you learn about Advantage Primary Care?

_____ Mailing _____ Drive-by/Billboard/Signs

_____ Online _____ Presentation @ work

_____ Social Media _____ Referral Friend/Family

_____ Other



REVIEW OF SYSTEMS (Children under 3 yr.)

(Please mark all that apply)

Patient Name: _____ Date: _____

Attention New Patients: How did you hear about Advantage Primary Care Clinic? Postcard in mail Presentation at work
 Newspaper ad Friend Billboard Referral Other

| | | |
|--|---|---|
| Constitutional | Y | N |
| Fever | | |
| Chills | | |
| Not Acting Like Self | | |
| Lost a Skill | | |
| Acting Fussy | | |
| Increased Sleeping | | |
| Wakes up Frequently | | |
| Recent Weight Gain (_____ lbs) | | |
| Recent Weight Loss (_____ lbs) | | |
| Head and Face | Y | N |
| Head Trauma | | |
| Scalp Tenderness | | |
| Facial Pain | | |
| Eyes | Y | N |
| Discharge from Eyes | | |
| Red Eyes | | |
| Dry Eyes | | |
| Crusted/Matted Eyes | | |
| Lack of Tears | | |
| Does not Follow Object/Movements with Eyes | | |
| ENT | Y | N |
| Pulling at Ears | | |
| Earache | | |
| Discharge from Ears | | |
| Nasal Discharge | | |
| Nosebleeds | | |
| Abnormal Crying | | |
| Little Reaction to Noise | | |
| Cardiovascular | Y | N |
| Heart Rate is Fast | | |
| Heart Rate is Slow | | |
| Swelling in Legs | | |
| Fingers or toes turning blue | | |
| Congenital Heart Defect | | |
| Respiratory | Y | N |
| Cough | | |
| Frequent Sneezing | | |
| Grunting | | |
| Wheezing | | |
| Fast Breathing | | |

| | | |
|----------------------------------|---|---|
| Nasal or Noisy Breathing | | |
| Sometimes Stops Breathing | | |
| Gastrointestinal | Y | N |
| Constipation | | |
| Increased Appetite | | |
| Decreased Appetite | | |
| Vomiting | | |
| Diarrhea | | |
| Blood in Stool | | |
| Spitting up anything | | |
| Excessive Gas | | |
| Abdominal pain | | |
| Genitourinary | | |
| Pain during urination | | |
| Decreased Urine Output | | |
| Increased Urine Output | | |
| Naval sticks out when crying | | |
| Musculoskeletal | Y | N |
| Limb Pain | | |
| Muscle Pain | | |
| Limb Swelling | | |
| Joint Swelling | | |
| Using Only One Hand | | |
| Joint Stiffness | | |
| SKIN | Y | N |
| Rash | | |
| Lesions | | |
| Dry Skin | | |
| Flakes on Scalp | | |
| Neurological | Y | N |
| Convulsions/Seizures | | |
| Limb Weakness | | |
| Psychiatric | Y | N |
| Not Sleeping Entire Night | | |
| Sleep Changes | | |
| Night Terrors | | |
| HEME/Lymphatic | Y | N |
| Swollen glands in Neck/Arms/Legs | | |
| Easy Bleeding | | |
| Easy Bruising | | |
| Other Problems: | | |



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CONTROLLED SUBSTANCE POLICY

PLEASE READ CAREFULLY

Dr. Rhonald Searcy does not provide chronic pain management. He will **NOT** be writing or refilling prescriptions for narcotics, other pain medications, soma, and other muscle relaxers or benzodiazepines (i.e.-xanax, klonopin, etc) sometimes used to treat severe anxiety and panic attacks. The above medications are examples but not a complete list.

I have read and understand the above agreement prior to seeing Dr. Rhonald Searcy. By signing below, I am verifying that I would like to be a patient of Dr. Searcy and that I understand he will not be writing or refilling the above type of medications. I agree that if I need such medication, I, myself will need to find or be established with another physician for treatment and management of pain and/or anxiety. My physician for pain management and/or anxiety will be responsible for writing and refilling such associated medication.

Patient Printed Name

Patient Signature

Date