PATIENT INFORMATION (PLEASE PRINT)

ADVANTAGE PRIMARY CARE

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: _____

City: _____ **State:** ____ **Zip:** _____

MARITAL STATUS: ☐ **Married** ☐ **Single** ☐ **Divorced**
☐ **Partner** ☐ **Widowed** **Separated**☐

Occupation: _____

Email:_____**@**_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

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

☐ Washington Regional Medical Center
☐ Newspaper or Magazine
☐ Recommended by friend or family member
☐ Drove by Location of Clinic
☐ Community or Company Health Fair
☐ Treated by Physician in hospital
☐ Internet
☐ Phone Directory (Yellow pages)
☐ Referred by a Physician: _____
☐ Employer
☐ Insurance Plan Directory
☐Return Patient/ Not Applicable
☐ 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_____ **Date:** _____/_____/_____

Signature (Patient or Parent/Guardian if minor)

ADVANTAGE PRIMARY CARE

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_____

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

Urinary Stream is decreased		
Females: Last Menstrual Period	**Date:**	
Females: Irregular Periods		
Females: Vaginal Discharge		
Females: Breast Lump		
Females: Nipple Discharge		
Males: Erectile Dysfunction		
Males: Penile Discharge		
Musculoskeletal	**Y**	**N**
Back Pain		
Neck Pain		
Joint Pain		
Joint Swelling		
Muscle Weakness		
Neurological	**Y**	**N**
Dizziness		
Difficulty Walking		
Headache		
Memory Loss		
Numbness in Extremities		
Tremor		
Seizures		
Psychiatric	**Y**	**N**
Anxiety		
Insomnia		
Depression		
Other Problems:		
Social History:		
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**

ADVANTAGE PRIMARY CARE

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:		

ADVANTAGE
PRIMARY CARE

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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