

# 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 \_\_\_\_\_

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

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

\*ATTENTION New Patients: How did you learn about the Advantage Primary Care Clinic?

- |                           |                 |
|---------------------------|-----------------|
| _____ Postcard in mail    | _____ Billboard |
| _____ 2015 Business Expo  | _____ Friend    |
| _____ Presentation @ work | _____ Referral  |
| _____                     | _____ 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

<b>Constitutional</b>	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)		
<b>Head and Face</b>	Y	N
Head Trauma		
Scalp Tenderness		
Facial Pain		
<b>Eyes</b>	Y	N
Discharge from Eyes		
Red Eyes		
Dry Eyes		
Crusted/Matted Eyes		
Lack of Tears		
Does not Follow Object/Movements with Eyes		
<b>ENT</b>	Y	N
Pulling at Ears		
Earache		
Discharge from Ears		
Nasal Discharge		
Nosebleeds		
Abnormal Crying		
Little Reaction to Noise		
<b>Cardiovascular</b>	Y	N
Heart Rate is Fast		
Heart Rate is Slow		
Swelling in Legs		
Fingers or toes turning blue		
Congenital Heart Defect		
<b>Respiratory</b>	Y	N
Cough		
Frequent Sneezing		
Grunting		
Wheezing		
Fast Breathing		

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