



507 W. Monroe Avenue, Suite A

Telephone: 479-463-8150 Fax: 479-463-8151

Email: [advantageprimarycare@wregional.com](mailto:advantageprimarycare@wregional.com) Patient Portal: [www.wrhealthlink.com](http://www.wrhealthlink.com)

Welcome to Advantage Primary Care! APC is a devoted primary care clinic committed to delivering comprehensive, patient centered care, while focusing on quality and safety. Whether we see you for an acute problem or ongoing chronic diagnosis we're here to make sure you get the care you need and deserve!

APC is a Patient Centered Medical Home. One thing you'll notice that sets us apart from your traditional Primary Care office is our use of Care Coordinators and Behavioral Health Specialists. Both play vital roles in assisting you reach your goals and staying healthy. We also place an emphasis on Wellness, Preventive Services, and Individualized Care Plans for chronic diseases such as diabetes, high blood pressure and depression. Please see the enclosed PCMH brochure for further details regarding our model and your place on the team. Lastly, we value your opinion and feedback regarding the treatment you receive so please, let us know how we're doing!

You can reach us for clinical advice during office hours via phone, fax, e-mail, patient portal, or by dropping into the clinic.

**Hours of Operation:** Monday 7:00 am - 4:00 pm  
Tuesday 7:00 am – 4:00 pm  
Wednesday 7:00 am – 12:00 pm  
Thursday 7:00 am – 4:00 pm  
Friday 7:00 am – 4:00 pm

**Laboratory/X-ray:** Monday, Tuesday, Thursday, Friday 7:00 am – 3:30 pm  
Wednesday's 7:00 am – 11:30 am.

**Behavioral Health Specialist:** available for appointments or drop-in's during hours of operation listed above.

**After Hours Availability:** We have providers on call after hours to assist you with your medical needs. To reach the on call provider call the main line (479) 463-8150 and follow the prompts. **IN THE CASE OF AN EMERGENCY ALWAYS CALL 911.** You may also send us an e-mail or message via your Patient Portal to be answered the following business day.

**After Hours Urgent Care Clinic:** APC is part of the Washington Regional Medical System. We recommend you use one of the Washington Regional Urgent Care clinics when possible for your after-hour needs. Both Washington Regional Urgent Care clinics

use the same Electronic Medical Record system as APC providing 24/7 access to your complete medical record, continuity of care, and reduced costs for you! Both Urgent Care clinics provide Urgent and Routine follow-up care, treat simple fractures, repair lacerations, provide on-site laboratory services and digital x-ray, and accept your insurance! We also understand these locations may not always be convenient for you so we've enclosed a *Release of Information* form for you to use whenever you receive care outside of the Washington Regional system so that we can obtain those records.

**Washington Regional Urgent Care – Fayetteville**

3 E. Appleby Road, Suite 101  
Fayetteville, AR, 72703  
Phone: 479-404-1010.  
Monday-Sunday 9:00am-9:00pm

**Washington Regional Urgent Care – Johnson**

3561 Johnson Mill Blvd., Suite 102  
Fayetteville AR 72704  
Phone: 479-404-4900  
Monday-Sunday 7:00am-7:00pm

**Patient Portal:** We have a secure online Patient Portal at [www.wrhealthlink.com](http://www.wrhealthlink.com). We will issue you your PIN and provide instructions how to register your account today. This is a very important tool and will be helpful if you ever find yourself needing medical attention outside of our office. Once registered, you can access your account 24/7 to view your medical records, medications, allergies, view recent diagnostic results, request appointments, send messages to your APC team, and much more!

**Appointments:** Please try to give a 24 hour notice if you're unable to keep your appointment. If you'd like to receive text reminders for your appointments, you may do so by texting WASHREG to 622622 or signing up for those through your Patient Portal account.

**Prescription Refills:** All prescription refills should be requested through your pharmacy first. If the pharmacy needs an authorization or prescription renewal they'll contact our office for you. Please allow two business days for all requests. *Refill requests are not an appropriate after hours call. Please plan accordingly so that you don't run out.*

Some medications require a *PRIOR AUTHORIZATION* from your insurance company and *may* take up to 72 so please plan accordingly.

**Fees-Insurance-Payments:** Health Care Insurance is intended to cover some but not all of the cost of your treatment. Most plans include co-payments which are due at the time of service in addition to any deductible or accrued debt. Please bring your insurance cards with you to each visit. Changes made to your insurance coverage should be reported immediately to ensure proper filling. As a courtesy, we file with Blue Cross Blue Shield, Medicare, and Medicaid. APC provides equal access to all patients accepted into the practice regardless of your insurance status. If you have a secondary plan not listed above, YOU will be responsible for that coinsurance and coverage amount at the time of service. We are sorry for any inconvenience in advance.

Thank you for choosing us to provide your care!

# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_



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**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 \_\_\_\_\_

<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		
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		
<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 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

<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>		



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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.

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Patient Printed Name

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Patient Signature

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Date