Welcome to Washington Regional Fayetteville Family Clinic!

Please complete the attached forms and return them to the office, mail, email, or fax as listed below. Once we receive your packet, we will call you to schedule.

Fayetteville Family Clinic
3 East Appleby Road, Suite 301
Fayetteville, AR 72703
Phone: 479-404-1200
Fax: 479-404-1201
fayettevillefamily@wregional.com

If you have insurance, please remember to bring your insurance card, and be prepared to pay any required co-pay at your appointment.

*If you have Medicaid insurance, please call Connect Care at 1-800-275-1131 and get assigned to **our** doctor prior to your appointment. If you are not assigned the day of your appointment, we will have to reschedule.*

Thank you for choosing Fayetteville Family Clinic for all your healthcare needs. We look forward to seeing you!

Cancellation/No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or do not show to your appointment, you may be preventing another patient from getting needed treatment. Appointments are in high demand and your early cancellation is greatly appreciated.

We require a 24-hour notice to cancel or reschedule an appointment. Three no shows could result in you being discharged from our practice. This policy enables us to better utilize available appointments for our patients in need of medical care.

Please call 479-404-1200 if you wish to reschedule. You may leave a detailed message on our voicemail. Please leave your name, date of birth and a good call back number. We will return your call and give you the next available appointment time. Thank you for your understanding and cooperation.

Phone Messages:

If you call after 2pm, your phone call may not be returned until the next business day.

Prescriptions:

Patients who take critical prescription medications are advised to adhere to the schedule of office visits and lab, as recommended by their doctor.

Please notify your pharmacy if you need a medication refill. The pharmacy will contact our office if a new prescription is needed.

Medication requests will be processed by the physician within the next 2 business days. Please call your pharmacy after this time to verify refills are ready.

Patients who use a mail order pharmacy should notify the nurse 1-2 weeks prior to running out of medication, so we can process your prescription and allow adequate time for mailing of the medication to your home.

Forms:

Please allow up to 3 business days for any forms to be filled out.

After Hours:

If you have a medical problem that cannot wait until the next business day, Washington Regional has Urgent Care locations throughout Northwest Arkansas. If you have an emergent question and need to reach a provider after hours, please call 479-463-1000 and ask to speak to the physician on call.

Please select: ( ) Dr. Tyler Brockman ( ) Dr. Steven Spencer ( ) Taesha Winford, APRN ( ) Dr. Kylie Rhodes

Patient Information- Please Print

Social Sec #: ______-____-________

Name: ____ Home Phone: _______________

Last First Mid Initial

Address:____ Work Phone: _______________

City: ____ Cell Phone: _________________

State: __________________________ Zip Code: ___________ DOB: ___/___/____ Age:___yrs

Sex: ☐ Male ☐ Female ☐Other **Email: ________________@________**

Marital Status:☐ Married ☐Single ☐ Divorced **Veteran: ☐Yes ☐ No**

☐Partner ☐ Widowed ☐Separated

Employer Status: ☐Full-Time ☐Part-Time ☐Not Employed ☐Self Employed

☐Active-Duty Military ☐Student ☐Disabled

☐Retired – if so, when? ______________

Employer: ____

Primary Care Physician: ____________________________________

Referral

Who referred you to our clinic? (**Please check box**)

☐ Washington Regional Medical Center ☐Community or company Health Fair

☐ Referred by a physician: ____________________ ☐ Newspaper or Magazine ☐ Employer

☐ Treated by Physician in hospital ☐ Recommended by a friend or family member

☐ Internet ☐Insurance Plan Directory ☐Drove by Location of Clinic ☐Phone Directory (Yellow Pages)

☐ 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 DOB: ____/____/_____

Occupation: _______________________________ Social Sec #: _______-_____-________

Emergency Contact Information

Emergency contact: __________________________ Cell: _______________________________

Address: ___________________________________ Home: _____________________________

City: ________________ State: _____ Zip: ________ Relationship to Patient: _______________

Primary Insurance

Patient's Relationship to Main Policy Holder: ☐Myself ☐Spouse ☐Child ☐ Other: _______________

Name of Insurance Company: ____

Insurance company Address: ____

City: _____________________________________ State: ______________________ Zip: ______________________

ID#: ____ Group#: ____

Insurance company's Phone Number: ____

Main Holder's Name: ________________________________ Main Holder's DOB: ______/______/______

Main Holder's Address: ______________________________ Main Holder's Soc Sec#: ____-____-_____

City: ____

State: _________________________ Zip: ________________

Secondary Insurance

Patient's Relationship to Main Policy Holder: ☐ Myself ☐Spouse ☐ Child ☐Other: _______________

Name of Insurance Company: ____

Insurance company Address: ____

City: _____________________________________ State: ______________________ Zip: ______________________

ID#: ____ Group#: ____

Insurance company's Phone Number: ____

Main Holder's Name: ________________________________ Main Holder's DOB: ______/______/______

Main Holder's Address: ______________________________ Main Holder's Soc Sec#: ____-____-_____

City: ____

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 Social Sec#: ______-_____-_____

Address: ____ Phone#: _________________________

Have you ever been seen as a 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: _______________________________________ Relationship with Patient: _________________

Name: _______________________________________ Relationship with Patient: _________________

Name: _______________________________________ Relationship with Patient: _________________

Preferred Language: ☐English ☐Spanish ☐Marshallese ☐Arabic ☐Decline ☐ Other: ____________

Race: ☐African American ☐Asian ☐European ☐Hawaiian/Other Pacific Islander ☐Marshallese ☐ Mexican American Indian ☐ Middle Eastern or North African ☐ Multiracial ☐ Native American Indian/Alaskan ☐Spanish American Indian ☐ White Caucasian ☐Unknown ☐ Decline ☐Other

Ethnicity (Origin): ☐ Hispanic or Latino ☐Not Hispanic or Latino ☐ Unknown ☐Decline

Contact Preference: ☐Home Phone ☐Cell Phone (Call) ☐Cell Phone (Text) ☐ Email

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 messaged 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 judgement 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)

Dr. Tyler Brockman, Dr. Steven Spencer, Dr. Kylie Rhodes and Taesha Winford, APRN **WILL NOT** chronically prescribe or refill the following list of medications:

__OPIATES__
Fentanyl (Actiq, Duragesic, Fentora)
Hydrocodone (Hysingla ER, Zohydro ER)
Hydrocodone/Acetaminophen (Lorcet, Lortab, Norco, Vicodin)
Hydromorphone (Dilaudid, Exalgo)
Meperidine (Demerol)
Methadone (Dolophine, Methadose)
Morphine (Astramorph, Avinza, Kadian, MS Contin, Ora-Morph SR)
Oxycodone (OxyContin, Oxecta, Roxicodone)
Oxycodone/Acetaminophen (Percocet, Endocet, Roxicet)
Oxycodone/Naloxone (Targiniq ER)

__BENZODIAZEPINES__
Alprazolam (Niravam, Xanax, Xanax XR)
Chlordiazepoxide (Librax)
Clobazam (Onfi)
Clonazepam (Klonopin)
Clorazepate (Tranxene T-Tab)
Diazepam (Valium)
Estazolam (ProSom)
Flurazepam (Dalmane)
Lorazepam (Ativan)
Midazolam (Versed)
Oxazepam (Serax)
Temazepam (Restoril)
Triazolam (Halcion)

__STIMULANTS__
Dexmethylphenidate (Focalin)
Dextroamphetamine (Dexedrine, Dextroamphetamine)
Lisdexamfetamine (Vyvanse)
Methylphenidate (Concerta, Daytrana, Metadate CD, Methylin, Ritalin)
Mixed salts (Amphetamine, Adderall)

Initials: __________ **Date: ____________**

PLEASE BE ADVISED

Dr. Tyler Brockman, Dr. Steven Spencer, Dr. Kylie Rhodes and Taesha Winford, APRN do not provide chronic pain management. They will not be writing or refilling prescriptions for narcotics, other pain medications, soma, and other muscle relaxers, or benzodiazepines (sometimes used to treat severe anxiety and panic attacks). The medications listed on the previous page are examples, but not a complete list.

I have read and understand the above agreement prior to seeing Dr. Tyler Brockman, Dr. Steven Spencer, Dr. Kylie Rhodes and/or Taesha Winford, APRN. By signing below, I am verifying that I would like to be a patient of Dr. Tyler Brockman, Dr. Steven Spencer, Dr. Kylie Rhodes and/or Taesha Winford, APRN, and that I understand they will not be writing or refilling the above type of medications. I agree, that if I need such medications, 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

Date: ___________________

Patient's Name: _____________________________________ DOB: __________________

Reason for your visit:

____

____

Please list all your medical problems or anything you regularly see a doctor for:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Please list all medication prescriptions, over the counter, vitamins/herbs, that you are currently taking.

Name of Medication	Dosage	Times per day	What medical problem/condition do you take this for?

Please list any allergies (medical, x-ray dyes, or non-medical) that you have and what reaction you have to these.

____

____

Please list all surgeries and the date of the surgeries.

____

____

Please list any medical problems you've had in the past.

____

____

Please list any hospitalizations, reason, and dates.

____

____

Family History of any of the following:

	Father	Mother	Sibling	Grandparent		Father	Mother	Sibling	Grandparent
Asthma					High Cholesterol				
Bleeding Disorder					Kidney Disease				
Cancer					Mental Illness				
Diabetes					Osteoporosis				
Epilepsy					Stroke				
Heart Disease					Thyroid Disease				
High Blood Pressure					Other				

Social History:

Do you use or have you ever used tobacco? ☐ No ☐ Yes

If yes, how much? ________________________________

If quit, when? ____

Do you or have you ever used alcohol? ☐ No ☐ Yes

How often: ☐ Never ☐ Rarely ☐ Occasionally ☐ Weekends ☐ Daily

Have you had?	**When?**
Tetanus Vaccine	
Flu Vaccine	
Pneumonia Vaccine	
Covid Vaccine	
Shingles Vaccine	
Pap Smear	
Bone Density	
Mammography	
Colonoscopy	
PSA Test (prostate)	
Annual Wellness Exam	