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
Fax: 479-404-1201
fayettevillefamilyclinic1@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!
# 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

Marital Status: [ ] Married  [ ] Single  [ ] Divorced

  [ ] 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: ________________________________

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# 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: ________________________________

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# Spouse/Parent Information

Spouse/Parent Name: ____________________________  Cell: ____________________________

Employer: ________________________________________  Work: _______________ Ext: ______

Work Address: ______________________________________

City: _______________  State: ____  Zip: _________

Spouse/Parent Sex: [ ] Male  [ ] Female

Occupation: ____________________________  Social Sec #: ______-____-______

Spouse/Parent DOB: ___/___/____

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# 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 □ Marshallse
□ 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 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 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 and Taesha Winford, APRN WILL NOT 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 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 and/or Taesha Winford, APRN. By signing below, I am verifying that I would like to be a patient of Dr. Tyler Brockman 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.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Times per day</th>
<th>What medical problem/condition do you take this for?</th>
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</tbody>
</table>

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:

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Grandparent</th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
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<td>Bleeding Disorder</td>
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<td>Cancer</td>
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<td>Diabetes</td>
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<td>Epilepsy</td>
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<td>Heart Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>Kidney Disease</td>
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<td>Mental Illness</td>
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<tr>
<td>Osteoporosis</td>
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<td>Stroke</td>
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<td>Thyroid Disease</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus Vaccine</td>
<td></td>
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<tr>
<td>Flu Vaccine</td>
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<tr>
<td>Pneumonia Vaccine</td>
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<tr>
<td>Pap Smear</td>
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<tr>
<td>Bone Density</td>
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<td>Mammography</td>
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<tr>
<td>Colonoscopy</td>
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<tr>
<td>PSA Test (prostate)</td>
<td></td>
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</tbody>
</table>