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
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!
Provider Requested (Please Circle): Dr. Tyler Brockman or Taesha Winford, APRN

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: ______________________________

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:** ___________________________
- **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:** _____________________________

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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_ _____________________________________________

**Signature (Patient or Parent/Guardian if minor)**

**Date:** _______/_____/______
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**
- Dexamfetamine (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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</thead>
<tbody>
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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>Asthma</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>High Cholesterol</td>
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<tr>
<td>Bleeding Disorder</td>
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<tr>
<td>Kidney Disease</td>
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<td>Cancer</td>
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<td>Mental Illness</td>
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<td>Diabetes</td>
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<td>Osteoporosis</td>
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<td>Epilepsy</td>
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<td>Stroke</td>
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<td>Heart Disease</td>
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<td>Thyroid Disease</td>
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<td>High Blood Pressure</td>
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<tr>
<td>Other</td>
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</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>
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<tr>
<td>Flu Vaccine</td>
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<tr>
<td>Pneumonia Vaccine</td>
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<tr>
<td>Covid 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>