Fayetteville Family Clinic
Washington Regional

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 #: _____-____-_____ **MRN #: _____**

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

☐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 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.

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	
Pap Smear	
Bone Density	
Mammography	
Colonoscopy	
PSA Test (prostate)	