DR. JEFFREY BELL
DR. JON BERRY
DR. GARETH ECK
DR. KAI MCCURDY
DR. BRIAN POTTORF
DR. STEPHEN WOOD
BRITTANY HULS, APRN
KAYLIE SLAUGHTER, APRN

Washington Regional General Surgery Clinic

Washington Regional

General Surgery Clinic
3264 N. North Hills Blvd.
Fayetteville, AR 72701
Telephone: 479.521.3300
Fax: 479.521.4705

NAME : _____ BIRTHDATE: _____

ADDRESS: _____ SSN: _____

IF PO BOX, 911 ADDRESS: _____

HOME PH# _____ CELL PH#: _____

EMAIL ADDRESS: _____ MARITAL STATUS: _____

CONTACT PREFERENCE: ☐ BY PHONE ☐ BY EMAIL ☐ BY PHONE & EMAIL ☐ DO NOT CONTACT (may need to complete a separate form)

EMPLOYER NAME: _____ EMPLOYER PH#: _____

EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ SELF EMPLOYED ☐ RETIRED ☐ ACTIVE MILITARY

OCCUPATION: _____ IF RETIRED, RETIRE DATE: _____ VETERAN: ☐ YES ☐ NO

GENDER: ☐ MALE ☐ FEMALE ☐ NEUTRAL ☐ BORN MALE/CURRENT FEMALE ☐ BORN FEMALE/CURRENT MALE

RACE: ☐WHITE ☐AFRICAN AMERICAN ☐ASIAN ☐NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN ☐HISPANIC OR LATINO ☐LATIN AMERICAN ☐DECLINE

ETHNICITY (ORIGIN): ☐ NOT HISPANIC OR LATINO ☐ HISPANIC OR LATINO ☐ UNKNOWN ☐ DECLINE

EMERGENCY CONTACTS

In order to protect your privacy, Cardiovascular and Thoracic Surgery Clinic asks you to list the family member, friends or any person(s) (***including but not limited to spouses, significant others, and legal representatives***) who we may contact or can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

1. NAME _____ RELATIONSHIP _____ PHONE _____
ADDRESS _____
EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ SELF EMPLOYED ☐ RETIRED ☐ ACTIVE MILITARY
OCCUPATION: _____ IF RETIRED, RETIRE DATE: _____ VETERAN: ☐ YES ☐ NO

2. NAME _____ RELATIONSHIP _____ PHONE _____
ADDRESS _____
EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ SELF EMPLOYED ☐ RETIRED ☐ ACTIVE MILITARY
OCCUPATION: _____ IF RETIRED, RETIRE DATE: _____ VETERAN: ☐ YES ☐ NO

PHYSICIAN CARE TEAM

PRIMARY CARE PHYSICIAN NAME: _____ PHONE _____
ADDRESS: _____
SECONDARY CARE PHYSICIAN NAME: _____ SPECIALITY: _____
ADDRESS & PHONE NUMBER: _____

PHARMACY

NAME: _____ PHONE _____
ADDRESS: _____
MAIL-ORDER PHARMACY NAME: _____
MAIL-ORDER PHARMACY ADDRESS: _____

Please bring your medications, or a list of them, to your office visit and ask your doctor to write refills for any medications you anticipate needing.

Patients who have been seen by the doctor at appropriate intervals may call for refills on some prescriptions (antibiotics excluded). You may call your pharmacy 2 - 3 days prior to running out of medication so the pharmacy can fax a refill request to the clinic. Please allow 48 hours for refill requests. Requests received after 2 p.m. will be not be reviewed until the next business day. No pain medication prescriptions will be written on Friday. Most pain medication prescriptions will require the patient or respresentative to pick up from our office. Please bring a photo ID at the time of pick up.

SIGNATURE: _____ Date: _____

Please bring the following to your appointment: Insurance cards & picture I.D, all medications or a list of medications, CD of testing if indicated (note: CDs will become patient records and not subject to return). Co-pay & co-insurance due at the time of appointment

Washington Regional General Surgery Clinic

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General Surgery Clinic
3284 N. Harth Hills Blvd
Fayetteville, AR 72701
Telephone: 479.521.3566
Fax: 479.521.4705

PATIENT NAME: _____ **DATE OF BIRTH:** _____

INSURANCE INFORMATION

1 PRIMARY INSURANCE NAME & POLICY NO. _____ POLICY HOLDER NAME/DOB: _____

2 SECONDARY INSURANCE NAME & POLICY NO. _____ POLICY HOLDER NAME/DOB: _____

3 TERTIARY INSURANCE NAME & POLICY NO. _____ POLICY HOLDER NAME/DOB: _____

MEDICARE POLICY

I request that payment of authorized Medicare benefits be made on my behalf to Washington Regional General Surgery Clinic for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

PAYMENT POLICY

Insurance Co-pays/co-insurance monies are due upfront at time of service. After all insurance monies have been received; you are immediately responsible for full payment of any remaining balance. If full payment cannot be made, it is your responsibility to contact the business office at 479-463-6000 to discuss a payment plan. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the answers on the first page. I certify this information is true and correct to the best knowledge. I will notify you of any changes in health status or the personal information.

Any information given to use will be used if needed to collect on a debt. We reserve the right to report delinquent balances to credit bureaus. We reserve the right to use a third-party collections agency, seek legal action, and/or petition the IRS under debtor intervention that may include IRS review/audit or a tax lien. We reserve the right to discontinue providing medical care if we are unable to collect for our services in a timely manner.

NO-SHOW POLICY

It is very important that you call 24 hours in advance to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office as soon as possible. On the second no-show or same-day cancellation/reschedule occurrence, there will be a $45 charge to your account not covered by insurance. After three consecutive no-show occurrences, the practice reserves the right to terminate our relationship with you.

MEDICAL RECORDS POLICY

A medical request signed by the patient is required to send or release records to anyone other than a medical provider listed on the care team.

AUTHORIZATION RELEASE

* 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 of copy of this authorization to be used in place of the original
* I consent for my photo to be taken
* I understand 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 involved in my care
* I give my permission for messages to be left on my answering machine or sent by e-mail
* I authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of this facility, 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 of treatment.
* I received a copy of the Notice of Privacy Practices for this facility and may request an additional copy at any time
* I permit this facility to obtain my medication history electronically
* I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging
* I authorize this facility to discuss my information with:

Name: _____ **Relation:** _____ **Phone#:** _____

Name: _____ **Relation:** _____ **Phone#:** _____

Name: _____ **Relation:** _____ **Phone#:** _____

Signature : _____ **Date:** _____

(Patient signature but parent signature if patient under 18 years of age)

Patient Representative (if applicable): _____

Relation of Representative: _____

NAME: _____ **DOB:** _____

REASON FOR VISIT: _____ **HEIGHT:** _____ **WEIGHT:** _____

FLU VACCINE THIS YEAR ☐ YES ☐ NO – IF YES, WHO ADMINISTERED VACCINE: _____

PAST MEDICAL HISTORY:

☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Prostate Problem
☐ Asthma	☐ Emphysema	☐ High Cholesterol	☐ Rheumatic Fever
☐ Atrial Fibrillation	☐ Fibromyalgia	☐ HIV Positive	☐ Seizures
☐ Bleeding Disorders	☐ Glaucoma	☐ Kidney Disease	☐ Stroke
☐ Bronchitis	☐ Gout	☐ Liver Disease	☐ Thyroid Problems
☐ Cancer	☐ Heart Attack	☐ Pacemaker	☐ Tuberculosis
☐ Congestive Heart Failure	☐ Hepatitis	☐ Pneumonia	☐ Ulcers

Other _____

PAST SURGICAL HISTORY:

OPERATION	WHEN AND WHERE	OPERATION	WHEN AND WHERE

Have you had a colonoscopy? ☐ YES ☐ NO Date performed: _____ **Normal? ☐ YES ☐ NO**
Any polyps? ☐ YES ☐ NO Explain: _____

MEDICATIONS: (Please list all your medications including inhalers, as well as vitamin and herb supplements.)

IF MORE LINES NEEDED, ADD SEPARATE PAGE **PLEASE DO NOT FORGET TO LIST ALL BLOOD THINNERS**

NAME	DOSE	HOW OFTEN PER DAY	PRESCRIBED BY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

ALLERGIES: (Please list all of your allergies or write "No Known Allergies".)

MEDICATION	REACTION	LAST ONSET	MEDICATION	REACTION	LAST ONSET
1			5		
2			6		
3			7		
4			8		
FOOD:					
OTHER:					

Reviewed by/Credentials: _____ Date: _____

NAME: _____ **DOB:** _____

SOCIAL HISTORY:

Married, Widowed, Single or Divorced (circle one) Number of children:_____ Age(s) of Child(ren): _____

Who lives in your home? _____

Do you smoke? Yes_____ No_____ How much? _____

(circle) Tobacco, E-cigarettes, Cigars, Pipe How often? _____

Chewing Tobacco or Vape Nicotine% _____ How long? _____

Did you ever smoke? Yes_____ No_____ When did you quit? _____

(circle) Tobacco, E-cigarettes, Cigars, Pipe How much? _____

Chewing Tobacco or Vape Nicotine% _____ How long? _____

Do you drink alcohol? Yes_____ No_____ If yes, how much?_____ how often?_____ (circle) beer, wine, liquor

Do you use illegal drugs? Yes_____ No_____ If so, what kind?_____

Are you concerned that you may have been exposed to HIV? Yes_____ No_____

(circle one) **Employed, Unemployed, Retired, Disabled**

What type of work do you currently do/retired from? _____

Religious Preference? _____ **Highest Level of Education?** _____

Native Language? _____ **Amount of family or social support? (Good/Poor/None)** _____

FAMILY HISTORY:

Member	Age	State of Health	Age at Death	Cause
Father				
Mother				
Brothers				
Sisters				

Do you have an Advance Directive or Living Will?

☐ YES, I have a Living Will on file ☐ YES, I have an Advance Directive on file

☐ NO, I don't have either ☐ Prefer not to disclose

If you have a Living Will or Advance Directive, is it current? ☐ YES ☐ NO

A healthcare proxy is a person you have appointed to make healthcare decisions for you if you lose the ability to make decisions for yourself. By appointing a healthcare agent, you can make sure that healthcare providers follow your wishes.

Do you have a healthcare proxy? ☐ YES ☐ NO Relation: _____

Healthcare proxy's: Full Name: _____ As of date: _____

Phone Number(s): _____ Address: _____ City/State/Zip: _____

HIPAA Disclosure Information: Authorization by: Patient or Legal Guardian (Name): _____

The physician/practice may use or disclose the following protected health information: ☐ Any and all

☐ Excepted from disclosure: _____

Disclosure of health information (select all): ☐ Any healthcare provider/facility ☐ OK to leave voicemail

☐ Names/relation of authorized people: _____ _____

_____ _____

Patient signature: _____ **Date:** _____

Reviewed by/Credentials: _____ Date: _____

Patient Name: _____ DOB: _____

Preferred Pharmacy/Location/Phone#: _____

Please mark "N" for **no** or "Y" for **yes** if you had any of the following **in the last 30 days**:

Constitutional:
- ☐ N ☐ Y Chills
- ☐ N ☐ Y Fatigue (tired)
- ☐ N ☐ Y Malaise
- ☐ N ☐ Y Fever
- ☐ N ☐ Y Night Sweats
- ☐ N ☐ Y Weight Gain
- ☐ N ☐ Y Weight Loss

HEENT:
- ☐ N ☐ Y Ear Drainage
- ☐ N ☐ Y Ear Pain
- ☐ N ☐ Y Eye Discharge
- ☐ N ☐ Y Eye Pain
- ☐ N ☐ Y Hearing Loss
- ☐ N ☐ Y Nasal Drainage
- ☐ N ☐ Y Sinus Pressure
- ☐ N ☐ Y Sore Throat
- ☐ N ☐ Y Visual Changes

Respiratory:
- ☐ N ☐ Y Chronic Cough
- ☐ N ☐ Y Cough
- ☐ N ☐ Y Known TB Exposure
- ☐ N ☐ Y Shortness of Breath
- ☐ N ☐ Y Wheezing

Cardiovascular:
- ☐ N ☐ Y Chest Pain
- ☐ N ☐ Y Claudication
- ☐ N ☐ Y Edema (swelling)
- ☐ N ☐ Y Palpitations

Gastrointestinal
- ☐ N ☐ Y Abdominal Pain
- ☐ N ☐ Y Blood in Stools
- ☐ N ☐ Y Change in Stools
- ☐ N ☐ Y Constipation
- ☐ N ☐ Y Diarrhea
- ☐ N ☐ Y Heartburn
- ☐ N ☐ Y Loss of Appetite
- ☐ N ☐ Y Nausea
- ☐ N ☐ Y Vomiting

Genitourinary:
- ☐ N ☐ Y Dribbling
- ☐ N ☐ Y Dysuria
- ☐ N ☐ Y Hematuria
- ☐ N ☐ Y Polyuria(genitourinary)
- ☐ N ☐ Y Slow Stream
- ☐ N ☐ Y Urinary Frequency
- ☐ N ☐ Y Urinary Incontinence
- ☐ N ☐ Y Urinary Retention

Reproductive:
- ☐ N ☐ Y Erectile Dysfunction
- ☐ N ☐ Y Penile Discharge
- ☐ N ☐ Y Sexual Dysfunction
- ☐ N ☐ Y Other: _____

Metabolic/Endocrine:
- ☐ N ☐ Y N Cold Intolerance
- ☐ N ☐ Y Heat Intolerance
- ☐ N ☐ Y Polydipsia
- ☐ N ☐ Y Polyphagia

Neurologic:
- ☐ N ☐ Y Dizziness
- ☐ N ☐ Y Extremity Numbness
- ☐ N ☐ Y Extremity Weakness
- ☐ N ☐ Y Gait Disturbance
- ☐ N ☐ Y Headache
- ☐ N ☐ Y Memory Impairment
- ☐ N ☐ Y Seizures
- ☐ N ☐ Y Tremors

Psychiatric:
- ☐ N ☐ Y Anxiety
- ☐ N ☐ Y Depression
- ☐ N ☐ Y Insomnia

Integumentary:
- ☐ N ☐ Y Brittle Hair
- ☐ N ☐ Y Brittle Nails
- ☐ N ☐ Y Hair Loss
- ☐ N ☐ Y Hirsutism
- ☐ N ☐ Y Hives
- ☐ N ☐ Y Pruritus
- ☐ N ☐ Y Mole Changes
- ☐ N ☐ Y Rash
- ☐ N ☐ Y Skin Lesions

Musculoskeletal:
- ☐ N ☐ Y Back Pain
- ☐ N ☐ Y Joint Pain
- ☐ N ☐ Y Swelling
- ☐ N ☐ Y Muscle Weakness
- ☐ N ☐ Y Neck Pain

Hematologic/Lymphatic:
- ☐ N ☐ Y Easy Bleeding
- ☐ N ☐ Y Easy Bruising
- ☐ N ☐ Y Lymphadenopathy

Immunologic:
- ☐ N ☐ Y Contact Allergy
- ☐ N ☐ Y Environmental Allergies
- ☐ N ☐ Y Food Allergies
- ☐ N ☐ Y Seasonal Allergies

Patient Signature: _____ Date: _____

PATIENT AGENDA

Please take a moment to answer the questions below to best use the time spent today with your provider.

Name: _____ **DOB:** _____ **Date:** _____

1. **What concerns do you want to discuss at today's appointment?**

_____

2. **What symptoms do you want your provider to be aware?**

_____

3. **What providers (hospital, Emergency Room, Urgent Care Clinic, Specialist, etc.) have you seen since your last visit or hospital stay?**

_____

4. **What questions do you have for your provider?**

_____

5. **Do you have specific requests for any of the following?** (be specific)
   a. New/refilled medications _____
   b. Tests/Referrals _____
   c. Completion of forms _____
   d. Work/School Forms _____
   e. Other _____

6. **Have you traveled outside the United States in the last 21 days?** (circle) Yes No

If so, please specify: Guinea, Libera, Nigeria, Senegal, Sierra Leone Other: _____

7. **Often, we will have medical/nursing/physician's assistant students in office. Do you have any objection to having a student present during your visit?** (circle)
   Yes No

8. **Have you ever tested positive for COVID-19?** (circle) Yes No
   If yes, please specify the date you were given a positive result: _____

9. **Have you had a COVID-19 vaccine?** (circle) Yes No
   If no, do you wish to schedule an appointment for vaccine? _____
   If yes, please specify the vaccine brand name given: _____
   Vaccine #1 date: _____ Vaccine #2 date: _____
   PLEASE GIVE THE FRONT DESK YOUR VACCINATION CARD TO MAKE A COPY FOR OUR CHART

DUE TO THE UNCERTAINTY OF THE COVID-19 PANDEMIC, PLEASE BE AWARE SCHEDULED SURGERY DATE/TIME/LOCATION MAY CHANGE. INITIALS: _____

Informed Consent to Schedule Surgery or Special Procedures

Authorization. I, _____, _____ authorize _____
(Print Name of Patient) (DOB) (Print Name of Practitioner)
and any appropriate designees selected by my Practitioner, to schedule surgery or special procedure(s).

My preferred date(s) or day of the week to have surgery: _____

_____

MANDATORY: COVID-19 pre-op testing will be required 72-hours prior to all surgery performed at Washington Regional Medical Center and North Hills Surgery Center. After testing, you will need to self-quarantine until surgery. In other words, you may not go to work, be out in public, or attend gatherings.

Colonoscopies performed at North Hills Surgery Center will not require a COVID-19 pre-op test.

I am unable to have surgery on the following dates (please review your calendar(s) starting tomorrow through the next 8 weeks): _____

_____

Initial	Disclosures (depending on circumstance, fees may be incurred separately)
_____	I understand if surgery scheduled on a date that is not listed above and I change my mind or need to reschedule, the office reserves the right to charge a $30.00 fee (not paid by insurance)
_____	I understand if I do not show for the required pre-surgical testing such as COVID-19 testing or pre-op lab and we are required to reschedule surgery; the office reserves the right to charge a $50.00 fee (not paid by insurance)
_____	I understand if I do not call to reschedule surgery 48-hours in advance or no-show to surgery, the office reserves the right to charge a $100.00 fee (not paid by insurance)
_____	I understand if FMLA forms are required by a patient or caregiver's employer, forms will not be complete until after surgery but a standard work release may be given upon request. The employee has 15 days after he/she receives FMLA forms to return to employer. If your practitioner is not given at least 7 days to complete, the office reserves the right to charge a $20.00 fee (not paid by insurance)

Preferred contact method for surgical instructions:

☐ phone (blank informational paperwork or booklets will be given prior to leaving today)
Primary number: _____ Alternate number: _____

☐ in-person (wait time may be approximately 20 +/- minutes from the time this is returned)

☐ mail ☐ via secure e-mail email address: _____

If calling, who may we speak to regarding surgical instructions:

☐ only myself ☐ only my spouse _____ ☐ other: _____

Patient/POA Signature: _____ **Date:** _____

If your preferred contact method is anything other than in-person, give form to check-out clerk

☐ I request a copy of this form returned to me

Washington Regional

wregional.com