Washington Regional

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

UNDER 18 PATIENT INFORMATION

First name: _____ Mid. Initial _____ Last name: _____

Date of birth: _____ SSN: _____ ☐ Male ☐ Female ☐ MTF ☐ FTM

Mailing address: _____

City & State: _____ Zip Code: _____

If P.O. Box – Street or 911 Address: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____ Preferred Contact: ☐ Home ☐ Cell ☐ Email

Referring Doctor: _____ Primary Care Doctor (if different): _____

PARENT/GUARDIAN INFORMATION

Father's name: _____ DOB: _____

Social Security Number: _____ Cell#: _____

Mailing address (if different from above): _____

City & State: _____ Zip Code: _____

Employer's Name: _____ Employer's Phone Number: _____

Employer's Address: _____

Father's Insurance Name/Policy Number/ Group Number: _____

Mother's name: _____ DOB: _____

Social Security Number: _____ Cell#: _____

Mailing address (if different from above): _____

City & State: _____ Zip Code: _____

Employer's Name: _____ Employer's Phone Number: _____

Employer's Address: _____

Mother's Insurance Name/Policy Number/ Group Number: _____

Emergency contact: _____ Home/Cell Ph#: _____

Address: _____ Relation 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 Date of Birth: ____/____/____

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 Date of Birth: ____/____/____

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

City: _____

State: _____ Zip: _____

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: _____

Please mark "Y" for **yes** or "N" for **no** if you recently have any of the following:

Constitutional:

☐ **Y** ☐ **N** Fever

☐ **Y** ☐ **N** Fatigue (tiredness)

☐ **Y** ☐ **N** Recent (unintentional)Weight Loss (____ lbs)

☐ **Y** ☐ **N** Recent Weight Gain (____ lbs)

☐ **Y** ☐ **N** Not feeling well

☐ **Y** ☐ **N** Chills

Dermatologic:

☐ **Y** ☐ **N** Rash Ulcer

☐ **Y** ☐ **N** Ulcer

HEENT:

☐ **Y** ☐ **N** Vision changes

☐ **Y** ☐ **N** Hearing loss

☐ **Y** ☐ **N** Nasal drainage

Respiratory:

☐ **Y** ☐ **N** Acute Cough

☐ **Y** ☐ **N** Shortness of breath

☐ **Y** ☐ **N** Wheezing

Cardiovascular:

☐ **Y** ☐ **N** Chest Pain

☐ **Y** ☐ **N** Palpitations

☐ **Y** ☐ **N** Edema (swelling)

Gastrointestinal:

☐ **Y** ☐ **N** Abdominal Pain

☐ **Y** ☐ **N** Blood in Stools

☐ **Y** ☐ **N** Constipation

☐ **Y** ☐ **N** Diarrhea

☐ **Y** ☐ **N** Heartburn

☐ **Y** ☐ **N** Nausea

☐ **Y** ☐ **N** Vomiting

Genitourinary:

☐ **Y** ☐ **N** Polyuria (excessive urine output)

☐ **Y** ☐ **N** Urinary frequency

☐ **Y** ☐ **N** Urinary incontinence (loss of control)

Reproductive:

☐ **Y** ☐ **N** Breast lump

☐ **Y** ☐ **N** Breast pain

☐ **Y** ☐ **N** Nipple pain

Metabolic/Endocrine:

☐ **Y** ☐ **N** Cold intolerance

☐ **Y** ☐ **N** Heat intolerance

Neurological:

☐ **Y** ☐ **N** Headache

☐ **Y** ☐ **N** Memory impairment

☐ **Y** ☐ **N** Dizziness

☐ **Y** ☐ **N** Seizures

☐ **Y** ☐ **N** Extremity numbness

☐ **Y** ☐ **N** Extremity weakness

Psychiatric:

☐ **Y** ☐ **N** Anxiety

☐ **Y** ☐ **N** Depression

☐ **Y** ☐ **N** Insomnia

Integumentary:

☐ **Y** ☐ **N** Hair loss

☐ **Y** ☐ **N** Hives

☐ **Y** ☐ **N** Rash

☐ **Y** ☐ **N** Skin lesion

☐ **Y** ☐ **N** Pruritis (itching)

Musculoskeletal:

☐ **Y** ☐ **N** Back pain

☐ **Y** ☐ **N** Joint pain

☐ **Y** ☐ **N** Joint swelling

☐ **Y** ☐ **N** Muscle weakness

☐ **Y** ☐ **N** Neck pain

_____

(Patient signature)

_____

(Today's date)

Washington Regional General Surgery

Washington Regional
Here for you

Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of General Surgery as their professional judgment may be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize General Surgery to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to General Surgery for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize General Surgery to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or another date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that General Surgery does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:
X_____

_____
(Patient or Parent/Guardian if under 18 years of age)

_____
Relationship of Guardian

_____
Date