

## General Surgery Clinic

**3 E. Appleby Road, Ste. 401**  
**Fayetteville, AR 72703**  
Inside William L. Bradley Plaza

**146 Passion Play Road, Ste. A**  
**Eureka Springs, AR 72632**  
Inside Eureka Springs Family Clinic

*If you are unable to keep your appointment, please notify our office at least 24-hours in advance at 479-404-2500.*

Complete this paperwork in the comfort of your home with your records and medications readily available. Please do not mail paperwork to the clinic, simply bring it to your appointment. **Incomplete paperwork may cause a delay in your appointment.**

Please note, our surgeons may be called away to surgery or delayed in arriving to the clinic due to surgery. Please call ahead if this could cause issues with your schedule. Upon arrival, please give the front desk the following:

- \*Your completed paperwork**
- \*A list of current medications (or bring your medication bottles for nurse review)**
- \*Driver's license or picture ID**
- \*Insurance cards**
- \*Any co-pay, deductible, or amount not covered by insurance**

We look forward to your visit! Please feel free to call **479-404-2500** with any questions or concerns.

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

IF P.O.BOX, 911 ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

CONTACT PREFERENCE: PHONE EMAIL DO NOT CONTACT

EMPLOYER NAME: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

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

OCCUPATION: \_\_\_\_\_ IF RETIRED, DATE: \_\_\_\_\_ VETERAN:  YES  NO

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

RACE:  AFRICAN AMERICAN  ASIAN  NATIVE AMERICAN/ALASKA NATIVE  NATIVE HAWAIIAN/OTHER  
PACIFIC ISLANDER  HISPANIC  WHITE  UNKNOWN  DECLINE

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

### **EMERGENCY CONTACTS**

In order to protect your privacy, Washington Regional General Surgery Clinic asks you to list the family members, friends or person(s) who we may contact or may contact us to make a request or inquire regarding your protected health information which includes medical condition and/or billing and financial information.

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ SSN#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE#: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ SSN#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE#: \_\_\_\_\_

### **PHYSICIAN CARE TEAM**

REFERRING DOCTOR: \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_

**PHARMACY**

**NAME OF PHARMACY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PLEASE ALLOW 48 BUSINESS HOURS FOR REFILL REQUESTS**

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

Do you have a health care proxy?  YES  NO

Relation: \_\_\_\_\_ Health care 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 health care provider/facility
- OK to leave voicemail.

<u>Name</u>	<u>Relation</u>	<u>Phone # of Authorized People:</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**Patient signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please fill out the patient health history as completely as possible. Please fill out front and back.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Health History

Workers Comp \_\_\_\_\_ Date of Injury \_\_\_\_\_

Flu vaccination this year? Yes \_\_\_ No \_\_\_ Approximate date: \_\_\_\_\_

Number of Falls Within the Past Year: None \_\_\_\_\_ With Injury \_\_\_\_\_ Without Injury \_\_\_\_\_

Two or more falls without injury  Two or more falls with injury

Feel Unsteady When Standing or Walking? Yes \_\_\_ No \_\_\_ Fear of falling? Yes \_\_\_ No \_\_\_

### PAST MEDICAL HISTORY:

Please place an X next to conditions you have today or have had in the past:

\_\_\_ Asthma \_\_\_ Breast Cancer \_\_\_ Cancer \_\_\_ Chronic Kidney Disease \_\_\_ Cirrhosis \_\_\_ Colon Polyps  
\_\_\_ Colorectal Malignancy \_\_\_ Congestive Heart Failure \_\_\_ Crohn's Disease/Colitis \_\_\_ Diabetes Type I or II (Insulin)  
\_\_\_ Diabetes Type I or II (Non-Insulin) \_\_\_ Diverticular Disease \_\_\_ Emphysema/COPD \_\_\_ Gastro Esophageal Reflux Disease  
\_\_\_ Heart Disease/Coronary Artery Disease \_\_\_ HIV Infect \_\_\_ Hypertension (Meds/Non-Meds) \_\_\_ Melanoma  
\_\_\_ Pancreatitis \_\_\_ Seizures \_\_\_ Stroke \_\_\_ Thyroid

Other: \_\_\_\_\_

### FAMILY HISTORY:

Please place an X next to any blood relative illnesses that have occurred:

\_\_\_ Diabetes \_\_\_ Cancer \_\_\_ Kidney Disease \_\_\_ Heart Disease \_\_\_ Stroke \_\_\_ Colon Cancer  
\_\_\_ Anesthesia Complications

Please place an X if allergic to the following:

\_\_\_ Penicillin \_\_\_ Latex \_\_\_ Sulfa Other: \_\_\_\_\_ Food Allergies: \_\_\_\_\_

Currently on Dialysis: Yes \_\_\_ No \_\_\_

Dialysis Center used: \_\_\_\_\_ Days: \_\_\_\_\_

Do you get pain pills (contract) from another doctor? Yes \_\_\_ No \_\_\_ Dr. \_\_\_\_\_

What date did the contract for narcotics start with another doctor: \_\_\_\_\_

Do you have a Medical Marijuana Card? Yes \_\_\_ No \_\_\_ Dr. \_\_\_\_\_

**PAST SURGICAL HISTORY:**

Please (x) the surgeries that you have had in the past:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Appendectomy                 | <input type="checkbox"/> Aortic Aneurysm Repair  | <input type="checkbox"/> Cholecystectomy (gallbladder) |
| <input type="checkbox"/> Biopsy                       | <input type="checkbox"/> Cardiac Cath            | <input type="checkbox"/> C-Section                     |
| <input type="checkbox"/> Colon Surgery                | <input type="checkbox"/> Colonoscopy             | <input type="checkbox"/> Groin/Hernia surgery          |
| <input type="checkbox"/> EGD                          | <input type="checkbox"/> Exploratory Laparotomy  | <input type="checkbox"/> Hysterectomy                  |
| <input type="checkbox"/> Hiatal/Paraesophageal hernia | <input type="checkbox"/> Hip Surgery             | <input type="checkbox"/> Knee Surgery                  |
| <input type="checkbox"/> Kidney Surgery               | <input type="checkbox"/> Lung Surgery            | <input type="checkbox"/> Tubal                         |
| <input type="checkbox"/> Mastectomy                   | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Ventral/Incisional Hernia     |
| <input type="checkbox"/> Umbilical Hernia Surgery     | <input type="checkbox"/> Vascular Surgery        |  |

Other: \_\_\_\_\_

**MEDICATIONS:**

Please provide the name and dosage of all medications, supplements, and vitamins that you are taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**SOCIAL HISTORY:**

Do you smoke? Yes\_\_\_ No\_\_\_ How much? \_\_\_\_\_

(Circle) Tobacco, E-Cigarettes, Cigars, Pipe How often? \_\_\_\_\_

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 illicit drugs? Yes \_\_\_ No \_\_\_ If so, what kind? \_\_\_\_\_

**Do you have an Advance Directive or Living Will?**

- Yes, I have a living will on file.
- No, I don't have either.

- Yes, I have an advance directive on file.
- Prefer not to disclose.

If you have a living will or advance directive, is it current? Yes \_\_\_\_\_ No \_\_\_\_\_