Har-Ber Family Clinic
Washington Regional

PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: _____-_____-_____ MRN#:_____

Name: _____
Last First Mid Initial

Home Phone: _____

Work Phone: _____Ext:_____

Address: _____

Cell Phone: _____

City: _____

Date of Birth: _____-____-_____ Age: _____yrs

State: _____ Zip Code: _____

Employer: _____

SEX: ☐ Male ☐ Female

Work Address: _____

City: _____ State: ____ Zip: _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced
☐ Partner ☐ Widowed Separated☐

Occupation: _____

Email:_____@_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

Who referred you to our clinic? (***PLEASE CHECK BOX***)

☐ Washington Regional Medical Center
☐ Newspaper or Magazine
☐ Recommended by friend or family member
☐ Drove by Location of Clinic
☐ Community or Company Health Fair
☐ Treated by Physician in hospital
☐ Internet
☐ Phone Directory (Yellow pages)
☐ Referred by a Physician: _____
☐ Employer
☐ Insurance Plan Directory
☐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 Date of Birth: _____/_____/_____

Occupation: _____

Social Sec. #: _____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____

Cell Phone: _____

Address: _____

Home Phone: _____

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 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: _____

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 **SS#**_____-_____-_____

Address: _____ **Phone#:**_____

Have you ever been seen as 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: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Preferred Language: ☐English ☐Spanish ☐Marshallese ☐Arabic ☐DECLINE OTHER: _____

Race: ☐ White ☐African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Native American Indian/ Alaskan ☐Hispanic ☐Unknown ☐ DECLINE

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐Unknown ☐DECLINE

Preferred Communication Method: ☐Print ☐Save to Flash Drive ☐DECLINE

Wellness Reminders: ☐Mail ☐Cell Phone ☐Home phone ☐Work Phone ☐DECLINE

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 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 judgment 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)

Har-Ber Family Clinic
813 Founders Park, Suite 206 Springdale, AR 72762

Washington Regional
Phone (479) 463-2333 Fax (479) 463-2357

New Patient Medical History

Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___/___/_____ Age: ____ Sex: ____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		❑ Heart Rhythm problems	
❑ High Cholesterol		❑ Asthma	
❑ Hypothyroidism (low thyroid)		❑ Cancer	
❑ COPD or Emphysema		❑ Liver Disease	
❑ Diabetes		❑ Kidney Disease	
❑ GERD		❑ Seizure Disorder	
❑ Depression or Anxiety			
❑ Heart Attacks or Blocked arteries			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operations / Hospitalizations / Injuries	Month / Yr	Operations / Hospitalizations / Injuries	Month / Yr
	/		/
	/		/
	/		/

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	Reaction	Medication / Food	Reaction

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status?	Age of children, if any?	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation?	Religious Preference?
Highest Level of Education:	What is your native language?	
What amount of family or social support do you have? Good/Poor/None		
Who all lives in your home?		
Do you use any illegal drugs? Yes/no If so what kind?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?	Do you use E-cigarettes or Vape?	
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	Have you had more than 2 partners in the last 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine Prevnar or Pneumovax or both?		Pap Smear HPV Test		Colon Cancer screen: Colonoscopy: Testing stool for blood:	
Hepatitis B Vaccine		Heart Catheterization		Endoscopy (EGD)	
Tetanus Vaccine		Bone Density (DEXA)		Heart Stress Test	
Shingles Vaccine		EKG		Aortic Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	
Lung Cancer Screen					

PLEASE BE ADVISED ALL NEW PATIENTS

Dr. Steven Spencer and Dr. Larisse Tantchou **WILL NOT** be prescribing or refilling prescriptions for controlled substances for chronic pain, anxiety/panic, adult ADD/ADHD, weight loss or narcolepsy/sleep apnea. It is the doctor's opinions that the prescribing of controlled substances for these medical conditions are best managed by specialist physicians. The following medications are examples and not a complete list.

CHRONIC PAIN: Opoids such as Fentanyl (Actiq, Duragesic, Fentora), Hydrocodone (Hysingla ER, Zohydro ER), Hydrocodone/Acetaminophen (Lorcet, Lortab, Norco, Vicodin), Hydromorphone (Dilaudid, Exalgo), Meperidine (Demerol), Methadone (Dolophine, Methadose), Morphone (Astramorph, Avinza, Kadian, MS Contin, Ora-Morph SR), Oxycodone (Percocet, Endocet, OxyContin, Oxecta, Roxicodone), Morphine (MS Contin), and/or muscle relaxers such as Carisoprodol (Soma).

ANXIETY/PANIC/ADULT ADD/ADHD: Benzodiazepines such as Alprazolam (Niravam, Xanax, Xanax XR), Chlordiazepoxide (Librax), Clobazam (Onfi), Clonazepam (Klonopin), Clorazepate (Tranxene T-Tab), Diazepam (Valium), Estazolam (ProSom), Flurazepam (Dalmane), Lorazepam (Ativan), Midazoam (Versed), Oxazepam (Serax), Temazepam (Restoril), Triazolam (Halcion), Methyphenidate (Concerta, Ritalin, Daytrana, Metadate CD, Methylin), Dextroamphetamine/Amphetamine (Adderall), Lisdexamfetamine (Vyvanse) or Mixed Salts Amphetamine (Adderall).

WEIGHT LOSS: Phentermine (Adipex-P)

NARCOLEPSY/SLEEP APNEA: Armodafinil (Nuvigil) or Modanfinil (Provigil)

I have read and understand the above agreement prior to seeing Dr. Steven Spencer or Dr. Larisse Tantchou. By signing below, I am verifying that I would like to be a patient of Dr. Spencer or Dr. Tantchou and that I understand they will NOT be prescribing or refilling any of the above medications. I agree that if I need such medications, I, myself will need to find another physician for treatment.

_____

Patient Printed Name

_____

Patient Signature Date