This is a friendly reminder for your upcoming appointment
At Fayetteville Family Clinic

Appointment Time: _____

Arrival Time: _____

Please complete the attached forms and bring them with you to your appointment.

If you have insurance, please remember to bring your insurance card
and be prepared to pay any required co-pay.

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.

If you need to reschedule your appointment, please call 479-404-1200.
If this appointment is not kept or cancelled at least 24 hours
prior to the appointment, it will NOT be rescheduled.

Thank you for choosing Fayetteville Family Clinic for 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 Employer:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced E-mail: _____@_____

☐ Partner ☐ Widowed ☐ Separated

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 ☐ Treated by Physician in hospital ☐ Employer ☐ 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 ☐ Mashallese ☐ Arabic ☐ Decline ☐ Other: _____

Race: ☐ African American ☐ Asian ☐ Hispanic ☐ Native American Indian/Alaskan

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown ☐ Decline

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

Preferred Communication Method: ☐ Print ☐ Decline

Contact Preference: ☐ Phone ☐ Email ☐ Both Phone & 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. Adkins, Dr. Pham, Dr. Pierre, 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)

PLEASE BE ADVISED

Dr. Johnny Adkins, Dr. Bao "Billy" Pham, Dr. Rosemay Pierre 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. Johnny Adkins, Dr. Bao "Billy" Pham, Dr. Rosemay Pierre and/or Taesha Winford, APRN. By signing below, I am verifying that I would like to be a patient of Dr. Johnny Adkins, Dr. Bao "Billy" Pham, Dr. Rosemay Pierre, 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 y ou 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)	