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

<table>
<thead>
<tr>
<th>Social Sec #: __<strong><strong>-</strong><strong>-</strong></strong>_-</th>
<th>MRN #: _____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: __________________________________</td>
<td>Home Phone: __________</td>
</tr>
<tr>
<td>Last</td>
<td>Work Phone: __________</td>
</tr>
<tr>
<td>First</td>
<td>Cell Phone: __________</td>
</tr>
<tr>
<td>Mid Initial</td>
<td>DOB: <em><strong>/</strong></em>/____ Age:___yrs</td>
</tr>
<tr>
<td>Address: _______________________________</td>
<td>Employer:______________</td>
</tr>
<tr>
<td>City: __________________________________</td>
<td>E-mail: ___________<strong>@</strong>____</td>
</tr>
<tr>
<td>State: ______________ State: ___ Zip: __________</td>
<td></td>
</tr>
<tr>
<td>Sex: □ Male □ Female □ Other</td>
<td>Spouse/Parent DOB: <em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Marital Status: □ Married □ Single □ Divorced</td>
<td>Social Sec #: __<strong><strong>-</strong><strong>-</strong></strong>_-</td>
</tr>
<tr>
<td>□ Partner □ Widowed □ Separated</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician: ____________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Spouse/Parent Name: ____________________________</th>
<th>Cell: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer: ____________________________</td>
<td>Work: ______________ Ext: ________</td>
</tr>
<tr>
<td>Work Address: ________________________________</td>
<td>Spouse/Parent Sex: □ Male □ Female</td>
</tr>
<tr>
<td>City: ______________ State: ___ Zip: __________</td>
<td>Spouse/Parent DOB: <em><strong>/</strong></em>/_____</td>
</tr>
<tr>
<td>Occupation: ____________________________________</td>
<td>Social Sec #: __<strong><strong>-</strong><strong>-</strong></strong>_-</td>
</tr>
</tbody>
</table>

### Emergency Contact Information

<table>
<thead>
<tr>
<th>Emergency contact: ____________________________</th>
<th>Cell: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: ________________________________</td>
<td>Home: __________________________</td>
</tr>
<tr>
<td>City: ______________ State: ____ Zip: __________</td>
<td>Relationship to Patient: __________</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
</tbody>
</table>
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: _______
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 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 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 (Dalmame)
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

Fayetteville Family Clinic  Patient History Form
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.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Times per day</th>
<th>What medical problem/condition do you take this for?</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Please list any allergies (medical, x-ray dyes, or non-medical) that you 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.
______________________________________________________________________________________________________________________________________________________________

Fayetteville Family Clinic  Patient History Form
Family History of any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Grandparent</th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Grandparent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td>High</td>
<td></td>
<td></td>
<td></td>
<td>Cholesterol</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td></td>
<td></td>
<td></td>
<td>Kidney</td>
<td></td>
<td></td>
<td></td>
<td>Disease</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Mental</td>
<td></td>
<td></td>
<td></td>
<td>Illness</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td>Osteoporosis</td>
<td></td>
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<td></td>
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<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
<td>Stroke</td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
<td>Thyroid</td>
<td></td>
<td></td>
<td></td>
<td>Disease</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus Vaccine</td>
<td></td>
</tr>
<tr>
<td>Flu Vaccine</td>
<td></td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td></td>
</tr>
<tr>
<td>Pap Smear</td>
<td></td>
</tr>
<tr>
<td>Bone Density</td>
<td></td>
</tr>
<tr>
<td>Mammography</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
</tr>
<tr>
<td>PSA test (prostate)</td>
<td></td>
</tr>
</tbody>
</table>

FFC 07/06/2018