

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

Appointment Time:

Arrival Time:

Please complete the attached forms and mail them back in the included self-addressed, postage included envelope or 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 all 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 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 (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 ALL NEW PATIENTS

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 above medications 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 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.

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)	