



Welcome to Washington Regional Farmington Family Clinic!

Please complete the attached forms and return them to the office by mail, e-mail, or fax at the address below. Once we receive your packet, we will call you to schedule.

Farmington Family Clinic
199 E. Main St.
Farmington, AR 72730
Fax: 479-463-1026
FarmingtonFamily@wregional.com

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

Once scheduled, if your appointment is not kept or cancelled at least 24 hours prior to the appointment, it will NOT be rescheduled.

The providers in our clinic do not manage chronic pain or certain psychiatric medications.

If you or your child need immunizations, please call ahead as we are limited on the vaccinations we provide.

Feel free to contact us, if you have any questions, at 479-463-1001.

Thank you,

Washington Regional
Farmington Family Clinic

Farmington Family Clinic

199 E. Main St. | Farmington, AR 72730 | 479.463.1001 phone | 479.463.1026 fax | wregional.com

PATIENT INFORMATION (PLEASE PRINT)

Name: _____ Date of Birth: ___/___/____ Sex: Male Female
Age: _____ Marital Status: _____ Social Security #: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Preferred provider (circle): Jamal Abdin, M.D. or Jantzen Slater, M.D. or Julia Fuster, PA-C
Who is responsible for payment: Myself Other: _____
Guarantor Name: _____ Relationship: _____
Guarantor Phone: _____ Social Security #: _____
Address: _____
Language: English Spanish Other : _____ Decline
Race: White Black Hispanic Asian Native Hawaiian/Other Pacific Islander
 Native American Indian/Alaskan Other _____ Decline
Ethnicity (Origin): Not Hispanic or Latino Hispanic or Latino Unknown Decline

PATIENT EMPLOYER

Employment Status: Full Time Part Time Unemployed Student
 Retired, date of retirement ___/___/____

Employer Name: _____
Employer Address: _____
Employer Phone: _____ Occupation: _____
Are you a Veteran: Yes No If so, have you retired? Yes No Date of Retirement: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Location: _____
Mail Order Pharmacy (if desired): _____ Location: _____

SPOUSE / PARENT INFORMATION

Spouse/Parent Name: _____ Date of Birth: ____/____/____

Cell: _____ Work Phone: _____

Work Address: _____

Occupation: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Date of Birth: _____

Cell: _____ Home Phone: _____

Address: _____

Relationship: _____ Employment Status: _____

Secondary Emergency Contact: _____ Relationship: _____

Cell: _____ Home Phone: _____

RELEASE OF INFORMATION

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

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 _____
Signature (Patient or Parent/Guardian if minor)

Date: _____

INSURANCE INFORMATION

Patient Name: _____

PRIMARY INSURANCE

Name of Insurance Company: _____

ID #: _____ Group #: _____

If Medicare managed, Medicare ID # (not social security #): _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company's Phone Number: _____

Patient's relationship to Main Policy Holder: Self Spouse Child Other: _____

Main Policy Holder's Name: _____ Social Security #: _____

Main Policy Holder's Date of Birth: ____/____/____ Main Policy Holder's sex: Male Female

Main Policy Holders Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

ID #: _____ Group #: _____

If Medicare managed, Medicare ID # (not social security #): _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company's Phone Number: _____

Patient's relationship to Main Policy Holder: Self Spouse Child Other: _____

Main Policy Holder's Name: _____ Social Security #: _____

Main Policy Holder's Date of Birth: ____/____/____ Main Policy Holder's sex: Male Female

Main Policy Holders Address: _____

City: _____ State: _____ Zip: _____

REFERRAL - Have you been a patient at one of our Washington Regional Medical System Clinics? Yes No If so, Where: _____ When: _____Who referred you to our clinic? Washington Regional Medical Center Friend/Family Drove by Location of Clinic Newspaper/Magazine Internet/Social Media Employer Other: _____

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 ◆ |
| |

| | | | | |
|---|---------------------|----------------------|------------------------|---------------------|
| ◆ Review of Systems ◆ | | | | |
| <i>Please review the following symptoms and circle those items that are a problem for you</i> | | | | |
| 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.

| | | | |
|--|-------------------|--|-------------------|
| ◆ Past Medical History ◆ | | | |
| <i>Condition / Disease</i> | <i>Year Began</i> | <i>Condition / Disease</i> | <i>Year Began</i> |
| <input type="checkbox"/> Hypertension | | <input type="checkbox"/> Heart Rhythm problems | |
| <input type="checkbox"/> High Cholesterol | | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Hypothyroidism (low thyroid) | | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> COPD or Emphysema | | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> GERD | | <input type="checkbox"/> Seizure Disorder | |
| <input type="checkbox"/> Depression or Anxiety | | | |
| <input type="checkbox"/> Heart Attacks or Blocked arteries | | | |

| ◆ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ◆ | | | |
|---|------------|--|------------|
| Operations / Hospitalizations / Injuries | Month / Yr | Operations / Hospitalizations / Injuries | Month / Yr |
| | / | | / |
| | / | | / |
| | / | | / |

| ◆ Family Health History ◆ | | | | |
|--|--------------------|-----------------------------|----------------|-----------------|
| <i>Please list below the health history of your blood (genetic) first degree relatives</i> | | | | |
| Relative | Living or Deceased | Current age or age at death | Cause of Death | Health Problems |
| Father: | | | | |
| Mother: | | | | |
| Brother(s): | | | | |
| | | | | |
| Sister(s): | | | | |
| | | | | |

| ◆ 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 | | |

| ◆ Other Physicians and Specialists ◆ |
|---|
| <i>List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)</i> |
| |
| |

| ◆ Medications, Vitamins and Herbal Supplements ◆ | | | | | |
|--|---------------|-----------------------------------|------------|----------|-----------------------------------|
| Medication | Strength | Number of pills taken & frequency | Medication | Strength | Number of pills taken & frequency |
| <i>Example: Tylenol</i> | <i>500 mg</i> | <i>1 - twice daily</i> | | | |
| | | | | | |
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| ◆ Medication or Food Allergies or Intolerances ◆ | | | |
|--|----------|-------------------|----------|
| <i>List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)</i> | | | |
| Medication / Food | Reaction | Medication / Food | Reaction |
| | | | |
| | | | |

| ◆ Disease Prevention and Health Maintenance ◆ | | | |
|--|---------|------------------------------------|-----------------------------|
| <i>Please list below the most recent dates of your vaccines and health screening tests</i> | | | |
| ◆ Immunizations | Date(s) | Immunizations | Date(s) |
| Flu | | Hepatitis B Vaccine | |
| Shingles or Shingrix | | Gardasil Vaccine | |
| Pneumonia (Prevnar, Pneumovax) or both? | | COVID Vaccine, please circle type: | |
| | | Moderna Pfizer Janssen | |
| Tetanus or Tdap | | | |
| ◆ Health Screening | Date | Name and Location of Facility | Results- Normal or Abnormal |
| Eye Exam | | | |
| Colon Cancer screening: colonoscopy, Cologuard, or testing stool for blood | | | |
| Mammogram | | | |
| Pap Smear | | | |