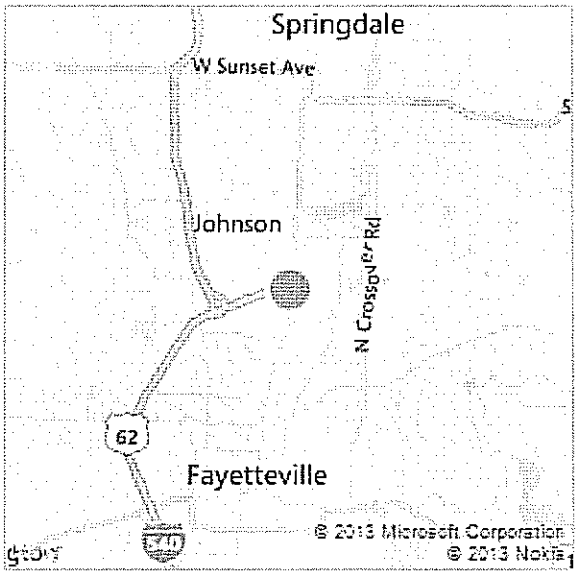
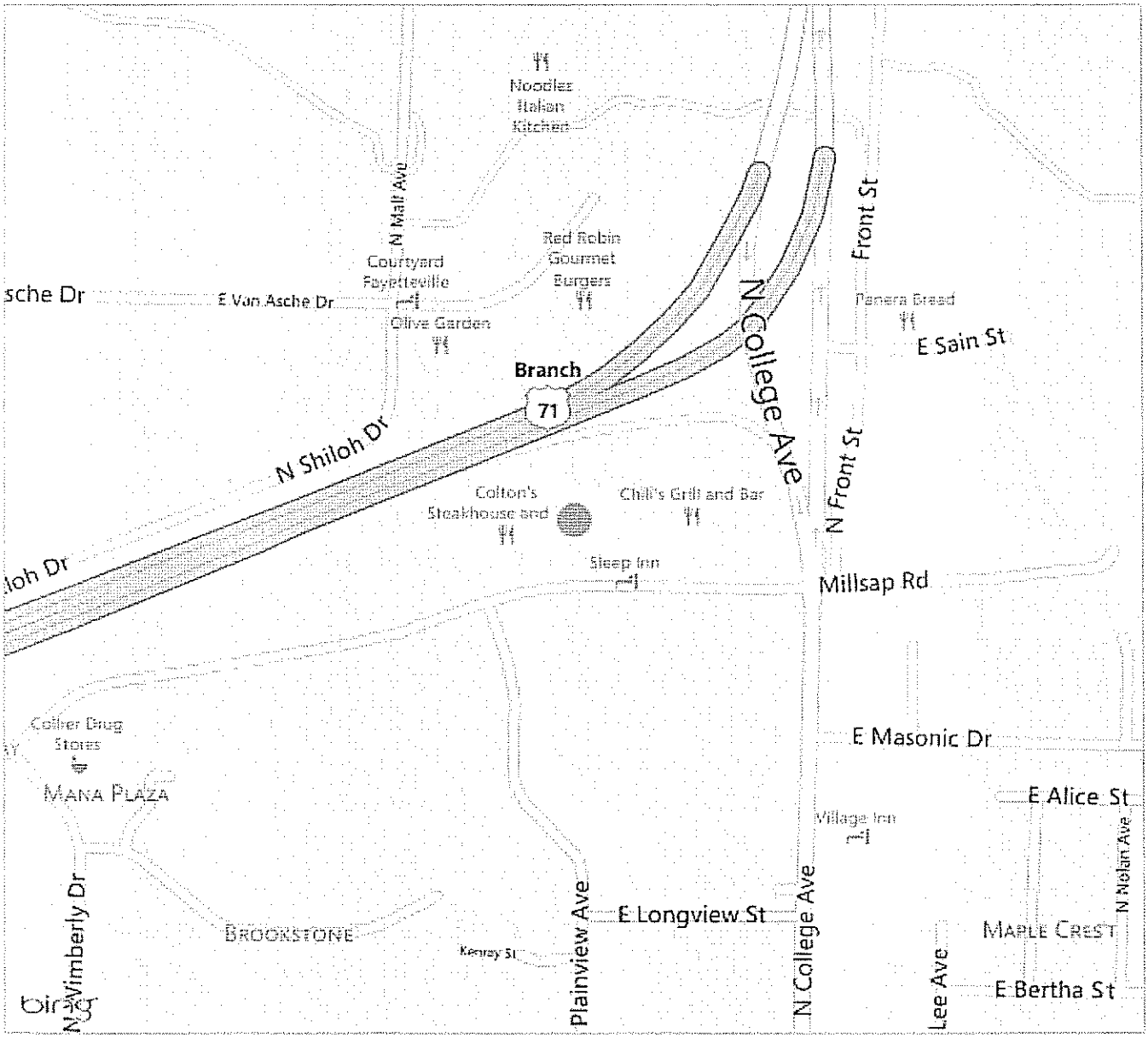
bing Maps

688 Millsap Rd, Fayetteville, AR 72703

Internal Medicine Associates
The entrance is at the back of the building overlooking the Fulbright Expressway

On the go? Use **m.bing.com** to find maps, directions, businesses, and more





Internal Medicine
Associates
Washington Regional

Due to the expansion of Dr.Allison Johnson's practice, as of January 1, 2014 we are updating our current policy regarding appointment times, late arrivals, and check in. You will need to check in 15 minutes prior to your scheduled appointment time. If you arrive after your appointment time, you could be asked to reschedule. If you are more than 10 minutes late, you will **need** to reschedule. Please allow driving time due to the road construction etc. This has always been her policy and due to the increase patient load we will be enforcing this policy to ensure that you are seen in a timely manner.

Upon arrival please be sure to check in with the receptionist at the front desk for your appointment, whether it is for lab, injections or doctor visit.

Please note, if you have lab ordered prior to your appointment that has not been done, we will need to reschedule the lab and doctor appointment. If you have lab done with an outside facility, other than Quest, we would ask you to bring a copy of those lab results with you to your appointment.

Thank you for your cooperation,

Washington Regional Internal Medicine Assoc.

Internal Medicine
Associates
Washington Regional

Welcome to Internal Medicine Associates! I would like to take this opportunity to introduce myself and our clinic to you.

Originally from Fayetteville, my husband and I moved back to Northwest Arkansas in 2009. We both graduated from the University of Arkansas for Medical Sciences in Little Rock and completed our residencies there as well. I stayed with the Department of Internal Medicine at UAMS first serving as chief resident and then as assistant professor of medicine while Jeff finished his residency in Orthopaedic Surgery. We relocated to Philadelphia for Jeff to complete a fellowship in hand and upper extremity surgery. While in Philadelphia, I was with the Department of Internal Medicine serving as assistant professor at Thomas Jefferson University. After the birth of our son Jack summer of 2009, we moved home, Jeff joining Ozark Orthopaedics and I joined W.D.M.D. Internal Medicine and Heart Clinic. I have had a wonderful three years with this practice, but as the clinic is in Rogers and transitioning to Northwest Health System, I began to look for a practice closer to home. When the opportunity presented itself to help develop a multidisciplinary internal medicine clinic in Fayetteville, I was absolutely thrilled to join this effort!

Internal Medicine Associates is a member of the Washington Regional outpatient clinic community. Our goal is to become a multidisciplinary team of physicians including both general internal medicine as well as internal medicine subspecialties. Our clinic is open from 7:30-4:30 Monday through Thursday. Fridays we are open from 7:30-12:30. My office staff is wonderful and here to answer your questions. Communication and availability to our patients is top priority to all of us. You should always receive a call back within 24 hours if you leave a message unless left on Friday afternoon. If this is the case, you will hear back from us on Monday. It is imperative that you bring all of your medications, both prescription and over the counter to your appointments so that we can review your medications with you. To help our clinic schedule stay time efficient, please arrive ten minutes prior to all scheduled appointments. If you are more than ten minutes late, please understand that our front office staff may ask you to reschedule your appointment. Enclosed is a history form that will help me to know you a little better. Please feel free to list any concerns that you would like to discuss at your appointment.

It is important for you to know that it is my distinct privilege to serve as your primary care physician. If we can be of any assistance to you prior to your appointment, please do not hesitate to call us. I look forward to meeting you!

Take care,

Allison Moss Johnson, M.D., F.A.C.P.

Internal Medicine Associates
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 authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging. 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)

PHYSICIAN INTAKE FORM

Patient Name_____

Past Medical History: Please list all medical conditions that you take medications for or have been treated for by a physician and any surgeries.

Medications: Please bring all medications with you to your appointment. You may list any concerns about your medications here.

Allergies: Please list medications and if known reaction to medication.

Family History: Please list all medical conditions of your immediate family (parents, siblings, children).

Personal Concerns: Please list any specific topics you would like to discuss at your appointment.

Signature of patient or legally authorized representative

Date