

NAME : _____ BIRTHDATE: _____

ADDRESS: _____ SSN: _____

IF PO BOX, 911 ADDRESS: _____

HOME PH# _____ CELL PH#: _____

EMAIL ADDRESS: _____ MARITAL STATUS: _____

CONTACT PREFERENCE: BY PHONE BY EMAIL BY PHONE & EMAIL DO NOT CONTACT (may need to complete a separate form)

EMPLOYER NAME: _____ EMPLOYER PH#: _____

EMPLOYMENT: FULL TIME PART TIME NOT EMPLOYED SELF EMPLOYED RETIRED ACTIVE MILITARY

OCCUPATION: _____ IF RETIRED, RETIRE DATE: _____ VETERAN: YES NO

GENDER: MALE FEMALE NEUTRAL BORN MALE/CURRENT FEMALE BORN FEMALE/CURRENT MALE

RACE: WHITE AFRICAN AMERICAN ASIAN NATIVE HAWAIIAN/PACIFIC ISLANDER AMERICAN INDIAN/ALASKAN HISPANIC OR LATINO LATIN AMERICAN DECLINE

ETHNICITY (ORIGIN): NOT HISPANIC OR LATINO HISPANIC OR LATINO UNKNOWN DECLINE

EMERGENCY CONTACTS

In order to protect your privacy, Washington Regional Walker Heart Institute asks you to list the family member, friends or any person(s) (***including but not limited to spouses, significant others, and legal representatives***) who we may contact or can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

1. NAME _____ RELATIONSHIP _____ PHONE _____
ADDRESS _____

EMPLOYMENT: FULL TIME PART TIME NOT EMPLOYED SELF EMPLOYED RETIRED ACTIVE MILITARY

OCCUPATION: _____ IF RETIRED, RETIRE DATE: _____ VETERAN: YES NO

2. NAME _____ RELATIONSHIP _____ PHONE _____
ADDRESS _____

EMPLOYMENT: FULL TIME PART TIME NOT EMPLOYED SELF EMPLOYED RETIRED ACTIVE MILITARY

OCCUPATION: _____ IF RETIRED, RETIRE DATE: _____ VETERAN: YES NO

PHYSICIAN CARE TEAM

PRIMARY CARE PHYSICIAN NAME: _____ PHONE _____

ADDRESS: _____

SECONDARY CARE PHYSICIAN NAME: _____ SPECIALITY: _____

ADDRESS & PHONE NUMBER: _____

PHARMACY

NAME: _____ PHONE _____

ADDRESS: _____

MAIL-ORDER PHARMACY NAME: _____

MAIL-ORDER PHARMACY ADDRESS: _____

Please bring your medications, or a list of them, to your office visit and ask your doctor to write refills for any medications you anticipate needing.

Patients who have been seen by the doctor at appropriate intervals may call for refills on some prescriptions (antibiotics excluded). You may call your pharmacy 2 - 3 days prior to running out of medication so the pharmacy can fax a refill request to the clinic. Please allow 48 hours for refill requests. Requests received after 2 p.m. will be not be reviewed until the next business day. No pain medication prescriptions will be written on Friday. Most pain medication prescriptions will require the patient or representative to pick up from our office. Please bring a photo ID at the time of pick up.

SIGNATURE: _____ Date: _____

Please bring the following to your appointment: Insurance cards & picture I.D, all medications or a list of medications, CD of testing if indicated (note: CDs will become patient records and not subject to return). Co-pay & co-insurance due at the time of appointment

NAME: _____ DOB: _____

PAST MEDICAL HISTORY:

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |

Other _____

PAST SURGICAL HISTORY:

LIST ALL SURGERIES AND APPROXIMATE DATE

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY:

Married, Widowed, Single or Divorced (circle one) Number of children: _____ Age(s) of Child(ren): _____

Who lives in your home? _____

Do you smoke? Yes _____ No _____ How much? _____

Tobacco, E-cigarettes, or Vape (circle) How long? _____

Did you ever smoke? Yes _____ No _____ When did you quit? _____

Tobacco, E-cigarettes, or Vape (circle) How much? _____

How long? _____

Do you drink alcohol? Yes _____ No _____ If yes, how much? _____

Do you use illegal drugs? Yes _____ No _____ If so, what kind? _____

Are you concerned that you may have been exposed to HIV? Yes _____ No _____

Employed, Unemployed, Retired, Disabled? (circle one)

What type of work do you currently do/retired from? _____

Religious Preference? _____ Highest Level of Education? _____

Native Language? _____ Amount of family or social support? (Good/Poor/None) _____

FAMILY HISTORY:

Member	Age	State of Health	Age at Death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

Reviewed by/Credentials: _____ Date: _____

NAME: _____ DOB: _____

MEDICATIONS:

(Please list all of your medications including inhalers, as well as vitamin and herb supplements.) Include name of medication, dose and number of times taken per day.

PHARMACY: (Please complete in full)

Name: _____ Phone #: _____

Pharmacy Address: _____

Mail-order Pharmacy Name: _____

Mail-order Pharmacy Address: _____

ALLERGIES: (Please list all of your medication allergies or write "No Known Allergies".)

REVIEW OF SYSTEMS:

Have you had any recent weight gain or loss (circle) How many pounds _____ Period of time _____

Have you had any unusual weakness or fatigue? Yes _____ No _____

Do you have any fever, chills or night sweats? (circle) Yes _____ No _____

Do you have any dizziness, vision change or headaches? (circle) Yes _____ No _____

Do you have a hearing aid or hearing loss? (circle) Yes _____ No _____

Do you have any nose drainage or bleeding? (circle) Yes _____ No _____

Do you have any difficulty swallowing? Yes _____ No _____

Do you have any hoarseness? Yes _____ No _____

Do you have any unusual sinus problems? Yes _____ No _____

Do you have any shortness of breath with or without exertion? (circle) Yes _____ No _____

Do you have difficulty breathing while lying down? Yes _____ No _____

Do you awaken at night short of breath? Yes _____ No _____

Have you had any wheezing? Yes _____ No _____

Have you coughed up blood or sputum recently? (circle) Yes _____ No _____

Do you have any chest pain? Yes _____ No _____

Have you had any loss of consciousness recently? Yes _____ No _____

Have you had any pounding or racing of the heart? Yes _____ No _____

Have you had any chest tightness or squeezing? Yes _____ No _____

Have you had any nausea or vomiting? (circle) Yes _____ No _____

Have you had any rectal bleeding, black or tarry stools? Yes _____ No _____

Does it burn when you urinate or is there blood in your urine? (circle) Yes _____ No _____

Do you have any muscle or back pain? Yes _____ No _____

Have you had any cramps, pain or swelling in your legs? Yes _____ No _____

Do you have any pain in your legs when you walk? (describe) _____

Do you have any color change in any of your extremities? Yes _____ No _____

Do you have any unusual skin rashes or itching? Yes _____ No _____

Have you had any changes in your speech or memory? Yes _____ No _____

Have you had any seizures? Yes _____ No _____

Have you been stressed, nervous, depressed? Yes _____ No _____

Have you had any unusual bleeding? Yes _____ No _____

Have you had any unusual swelling in the glands of your neck, under your arms, or in your groin? (circle) Yes _____ No _____

Reviewed by/Credentials: _____ Date: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

INSURANCE INFORMATION

- | | |
|---|-------------------------------|
| 1 PRIMARY INSURANCE NAME & POLICY NO. _____ | POLICY HOLDER NAME/DOB: _____ |
| 2 SECONDARY INSURANCE NAME & POLICY NO. _____ | POLICY HOLDER NAME/DOB: _____ |
| 3 TERTIARY INSURANCE NAME & POLICY NO. _____ | POLICY HOLDER NAME/DOB: _____ |

MEDICARE POLICY

I request that payment of authorized Medicare benefits be made on my behalf to Washington Regional Medical System for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

PAYMENT POLICY

Insurance Co-pays/co-insurance monies are due upfront at time of service. After all insurance monies have been received; you are immediately responsible for full payment of any remaining balance. If full payment cannot be made, it is your responsibility to contact the business office at 479-463-6000 to discuss a payment plan. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the answers on the first page. I certify this information is true and correct to the best knowledge. I will notify you of any changes in health status or the personal information.

Any information given to use will be used if needed to collect on a debt. We reserve the right to report delinquent balances to credit bureaus. We reserve the right to use a third-party collections agency, seek legal action, and/or petition the IRS under debtor intervention that may include IRS review/audit or a tax lien. We reserve the right to discontinue providing medical care if we are unable to collect for our services in a timely manner.

NO-SHOW POLICY

It is very important that you call 24 hours in advance to cancel your appointment. If for any reason you need to cancel or reschedule an appointment, please notify our office as soon as possible. On the second no-show or same-day cancellation/reschedule occurrence, there may be a charge to your account not covered by insurance. After three consecutive no-show occurrences, the practice reserves the right to terminate our relationship with you.

MEDICAL RECORDS POLICY

A medical request signed by the patient is required to send or release records to anyone other than a medical provider listed on the care team.

AUTHORIZATION RELEASE

- * 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 understand I am responsible for any amount not covered by insurance
- * I permit of copy of this authorization to be used in place of the original
- * I consent for my photo to be taken
- * I authorize and consent to the rendering of medical care including diagnostic procedures and medical treatment
- * I permit the faxing and electronic transmission of medical information to other health care providers involved in my care
- * I give my permission for messages to be left on my answering machine or sent by e-mail
- * I authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of this facility, 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 of treatment.
- * I understand the clinic may mail to your home, or other designated location, any items that assist in carrying out operations such as appointment reminders or test results
- * I received a copy of the Notice of Privacy Practices related to HIPAA for this facility and may request an additional copy at any time
- * I permit this facility to obtain my medication history electronically
- * 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 authorize this facility to discuss my information with:

Name: _____ Relation: _____ Phone#: _____

Name: _____ Relation: _____ Phone#: _____

Name: _____ Relation: _____ Phone#: _____

Signature : _____ **Date:** _____

(Patient signature but parent signature if patient under 18 years of age)

Patient Representative (if applicable): _____

Relation of Representative: _____