Welcome to Washington Regional Fayetteville Family Clinic!

Please complete the attached forms and return them to the office, mail, email, or fax as listed below. Once we receive your packet, we will call you to schedule.

Fayetteville Family Clinic
3 East Appleby Road, Suite 301
Fayetteville, AR 72703
Fax: 479-404-1201
fayettevillefamilyclinic1@wregional.com

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

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.

Thank you for choosing Fayetteville Family Clinic for all your healthcare needs. We look forward to seeing you!
Patient Information – Please print

Social Sec #: ______ - ____ - ______
Name: ____________________________________________
   Last      First     Mid Initial
Home Phone: ____________________________
Address: ________________________________________
City: ____________________________________________
State: __________________________ Zip Code: __________
DOB: ____/____/____ Age: ____yrs
Sex:  ☐ Male  ☐ Female  ☐ Other
Marital Status: ☐ Married  ☐ Single  ☐ Divorced
   ☐ Partner  ☐ Widowed  ☐ Separated
Employer: __________________________
Email: _________@_____
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  ☐ Employer
☐ Treated by Physician in hospital  ☐ 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: __________________________
Employer: __________________________
Work Address: __________________________
City: _______________ State: ____ Zip: _______
Occupation: __________________________
Spouse/Parent Sex: ☐ Male  ☐ Female
Spouse/Parent DOB: ____/____/____
Social Sec #: ______ - ____ - ______

Emergency Contact Information
Emergency contact: __________________________
Address: __________________________
City: _______________ State: ____ Zip: ______
Cell: __________________________
Home: __________________________
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)
Responsibility 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 □Marshallese □Arabic □Decline □Other: __________
Race: □African American □Asian □European □Hawaiian/Other Pacific Islander □Marshallese
□Mexican American Indian □Middle Eastern or North African □Multiracial
□Native American Indian/Alaskan □Spanish American Indian □White Caucasian
□Unknown □Decline □Other
Ethnicity (Origin): □Hispanic or Latino □Not Hispanic or Latino □Unknown □Decline

Contact Preference: □Home Phone □Cell Phone (Call) □Cell Phone (Text) □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. Tyler Brockman 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**
- Dexamfetamine (Focalin)
- Dextroamphetamine (Dexedrine, Dextroamphetamine)
- Lisdexamfetamine (Vyvanse)
- Methylphenidate (Concerta, Daytrana, Metadate CD, Methylin, Ritalin)
- Mixed salts (Amphetamine, Adderall)
PLEASE BE ADVISED

Dr. Tyler Brockman 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. Tyler Brockman and/or Taesha Winford, APRN. By signing below, I am verifying that I would like to be a patient of Dr. Tyler Brockman 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.

<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>
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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:

<table>
<thead>
<tr>
<th>Condition</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>
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<td>High Cholesterol</td>
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<td>Bleeding Disorder</td>
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<td>Kidney Disease</td>
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<td>Cancer</td>
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<td>Mental Illness</td>
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<td>Diabetes</td>
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<td>Osteoporosis</td>
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<td>Epilepsy</td>
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<td>Stroke</td>
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<td>Heart Disease</td>
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<td>Thyroid Disease</td>
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<td>High Blood Pressure</td>
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<td>Other</td>
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</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>
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<tbody>
<tr>
<td>Tetanus Vaccine</td>
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<tr>
<td>Flu Vaccine</td>
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<tr>
<td>Pneumonia Vaccine</td>
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<tr>
<td>Pap Smear</td>
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<tr>
<td>Bone Density</td>
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<td>Mammography</td>
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<tr>
<td>Colonoscopy</td>
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<tr>
<td>PSA Test (prostate)</td>
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</table>