Patient Information Form

Barg Family Clinic - Bryant Family Clinic - Little Rock Family Practice - Maple Creek Medical Clinic

Arkansas Family Care Network

☐ New Patient

☐ Established Patient

ACCOUNT NUMBER:

Is this work or accident related? ☐ NO ☐ YES Date of Injury _____

PATIENT INFORMATION

PATIENT NAME (LAST)	FIRST		HOME PHONE
ADDRESS			CELL PHONE
CITY, STATE	ZIP	D.O.B.	SOCIAL SECURITY
EMAIL ADDRESS		GENDER	MARITAL STATUS
EMPLOYER	EMPLOYER ADDRESS		
EMPLOYER PHONE	EXT	REFERRING PHYSICAN	
SPOUSE NAME		PHONE NUMBER	
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT		PHONE NUMBER

GUARANTOR/RESPONSIBLE BILLING PARTY INFORMATION

GUARANTOR	SOCIAL SECURITY	PHONE NUMBER
BILLING ADDRESS		
CITY, STATE	ZIP	EMPLOYER
EMPLOYER ADDRESS		EMPLOYER PHONE

INSURANCE INFORMATION (Please present your insurance cards/forms to receptionist)

PRIMARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		
SECONDARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		
TERTIARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR FINANCIAL RESPONSIBILITY IS TO ENSURE ARKANSAS FAMILY CARE NETWORK IS PAID FOR SERVICES RENDERED. THIS INCLUDES LIABILITY COVERED INJURIES, AS BILLS WILL NOT BE POSTPONED IN ANTICIPATION OF LEGAL SETTLEMENT. INFORMATION WILL BE PROVIDED TO YOU TO FILE YOUR OWN INSURANCE AND SUPPLIED TO YOUR ATTORNEY UPON REQUEST.

I HEREBY AUTHORIZE ARKANSAS FAMILY CARE NETWORK DOCTORS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A PATIENT.

_____ _____

Signature of patient or responsible party Date

Past Medical History

Patient Name: _____ DOB: _____ Date: _____

Pharmacy Name & Location: _____

Previous PCP: _____ Reason for Leaving: _____

How did you hear about us? _____

Past Medical History: Please check if you have had the following:

Cardiovascular
- ☐ High Blood Pressure
- ☐ Heart Attack, Year: _____
- ☐ High Cholesterol
- ☐ Atrial Fib
- ☐ Congestive Heart Failure (CHF)
- ☐ Blood Clots
- ☐ Peripheral Vascular Disease

Endocrinology
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Pituitary Disorder
- ☐ Adrenal Disorder
- ☐ Testosterone Deficiency

Pulmonary
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Pulmonary Nodule

Neurology
- ☐ Stroke, Year: _____
- ☐ Dementia
- ☐ Epilepsy/Seizure Disorder
- ☐ Migraine Headaches
- ☐ Pseudotumor Cerebri
- ☐ Restless Legs Syndrome
- ☐ Bell's Palsy
- ☐ Multiple Sclerosis
- ☐ Vertigo
- ☐ Tinnitis

Gastroenterology
- ☐ Acid Reflux/GERD
- ☐ Liver Disease/Hepatitis
- ☐ Celiac Disease
- ☐ Ulcerative Colitis
- ☐ IBS
- ☐ Diverticulosis

Nephrology
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones

Hematology/Oncology
- ☐ Anemia
- ☐ Sickle Cell Disease/Trait
- ☐ Bleeding Disorder
- ☐ Cancer
  Type: _____

Psychiatry
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Insomnia
- ☐ ADD/ADHD
- ☐ PTSD
- ☐ Schizophrenia

Rheumatology
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Scleroderma

Infectious Disease
- ☐ +HIV or AIDS
- ☐ Tuberculosis
- ☐ COVID 19
- ☐ Herpes

Gynecology
- ☐ PCOS
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Menopause

Urology
- ☐ BPH
- ☐ Erectile Dysfunction

Ophthalmology
- ☐ Glaucoma
- ☐ Cataracts

Dermatology
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Acne

Orthopedic
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Pain
  Where? _____

Allergy/Immunology
- ☐ Environmental/Seasonal Allergies
- ☐ Immunodeficiency

Other: _____

_____

If you are **diabetic**, when was your last HgbA1C? _____ Result? _____

When was your last dilated eye exam? _____

What was the result? _____

Who was the ophthalmologist/optometrist? _____

When was your last diabetic foot exam? _____

Exam		**Date of Last Exam**	**Result**	**Location**	**Doctor**
Pap Smear	(ages 21-65)				
Mammogram	(ages 40-75)				
Bone Density	(over 65)				
Colonoscopy	(over 50)				
PSA	(over 50)				

Continued .....

Past Medical History (continued) Patient Name: _____

Immunizations: Please indicate if you have had the following immunizations and the approximate year

	Yes	No	Year		Yes	No	Year
Pneumovax (age > 65)	Yes	No	_____	Shingrix (age>50)	Yes	No	_____
Prevnar (age > 65)	Yes	No	_____	Tetanus (every 10 yrs)	Yes	No	_____
Flu (yearly)	Yes	No	_____	HPV (age 11-26)	Yes	No	_____
Covid (P,M,J&J)	Yes	No	_____				

Please list any specialists. (ex. Cardiology, Pulmonary, Neurology, Nephrology, Endocrinology, Gastroenterology, Rheumatology, Pain Management, OBGYN, Ophthalmology, Urology, ENT, Podiatry)

Diagnosis	**Specialist Type**	**Name**

Allergies: Please list all drug allergies and/or other allergies

Drug	**Reaction**

Medications: Please list all current medications (including over-the-counter medications), dosages, how you take them and who prescribes them

Medication	**Dosage**	**Frequency**	**Prescribing Dr.**

Past Medical History (continued) Patient Name: _____

Surgeries

Date	**Surgery**	**Reason**

Hospitalizations (other than those associated with surgeries listed above)

Date	**Hospital**	**Reason**

Tobacco Use

Are you a ☐ current smoker ☐ former smoker ☐ nonsmoker

If you are a **current or former smoker,** please list how many packs per day: _____

and for how many years: _____ . Quit date: _____

Have you had screening for an Abdominal Aortic Aneurysm? Yes _____ No_____

Have you had screening for Lung Cancer by Chest CT? Yes _____ No_____

Sexual History:

Have you had sex in the past 12 months?_____

Have you ever had an STD?_____

If yes, which one?_____ When? _____

Any history of sexual abuse? Yes _____ No_____

Have you used **drugs** other than those for medical reasons in the past 12 months? Yes _____ No _____

If yes, What drug? _____ How often? _____

Have you had a drink containing **alcohol** in the past 12 months? Yes_____ No_____

If yes, How often? _____ How many at each sitting? _____

How often have you had 6 or more drink on one occasion in the past year? _____

Describe your average daily caffeine intake: _____

Describe any regular exercise: _____

Describe your living situation, including who you live with: _____

_____

What is your Martial Status? _____Partner's Name: _____

What is your **occupation**? _____

Any known exposures? _____

Past Medical History (continued) Patient Name: _____

Family History

Members	Status (alive/deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	Stroke	Kidney Disease	Mental Illness (type)	Cancer (type)	Other
Mother										
Father										
Mom's Dad										
Mom's Mom										
Dad's Dad										
Dad's Mom										
Siblings										
Son(s)										
Daughter(s)										

How many siblings do you have? Brothers _____ Sisters_____
How many children do you have? Boys _____ Girls _____

Depression Screening

Do you have little interest or pleasure in doing things? Yes _____ No_____
Do you feel down, depressed or hopeless? Yes _____ No_____

If you answered **YES**, to either of the above questions, complete the following:

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed or the opposite being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

(Staff Only: if PHQ9>9 add CPT F34.1, Document Intervention)

Fall Risk Assessment

If you are **65 years of age or older**, please answer the following:

Have you fallen within the last 6 months? Yes _____ No_____
Do you have a history of falls? Yes _____ No_____
Do you take precautions to prevent falls? Yes _____ No_____
Are you taking any medications that might affect your balance? Yes _____ No_____

ARKANSAS FAMILY CARE NETWORK

ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Arkansas Family Care Network's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services.

Signature: _____ **Date:** _____

Print Name: _____**Date of Birth:** _____

If you are not the patient, please fill out the following information:

Name:_____
Relationship to Patient: _____
Address: _____
Telephone: _____

Please furnish a copy of any conservator/guardianship papers with this form.

IF YOU WOULD LIKE SOMEONE ELSE TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION PLEASE FILL OUT INFORMATION BELOW:

I, _____, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION:

1._____ 3._____

2._____ 4._____

No Show & Cancellation Policy

Bryant Family Clinic

Dear Valued Patient,

Patients who are not able to keep their appointments are asked to provide timely notice of cancellation prior to their appointment time. Proving the required notice gives us the opportunity to schedule patients who may need to be seen urgently.

A no show is defined as a scheduled appointment that a patient does not keep.

Any appointment cancelled or rescheduled *less than 24 hours* before the scheduled appointment time will be treated as a no show and the below fees will apply.

First Occurrence:	A $25 fee will be charged
Second Occurrence:	A $25 fee will be charged with a reminder letter of next occurrence will result in dismissal from clinic.
Third Occurrence:	A $25 fee will be charged and dismissal from the clinic

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Signature Date

BRYANT FAMILY CLINIC, P.A.

A Member of Arkansas Family Care Network

AUTHORIZATION TO RELEASE AND/OR RECEIVE RECORDS

PATIENT NAME: _____

DOB: _____ SSN: _____ PHONE # _____

ADDRESS: _____

I hereby authorize BRYANT FAMILY CLINIC to:

◯ Release copies of billing or medical record to the following persons or entities.

◯ Receive copies of billing or medical records from the following persons or entities.

_____

_____

The following information shall be obtained and/or release pursuant to the authorization:

◯ History and Physical	◯ Operative Report
◯ Pathology Report	◯ Radiology Report
◯ Billing Records	◯ Other (specify)
◯ Entire Designated Record Set	_____

Information may be released in writing, verbally, or by video, fax, photocopy or microfilm

I request that the above information be released for the following dates of service:

_____

NOTICE TO THE PATIENT/PATIENT REPRESENTATIVE: If the recipient of the information disclosed pursuant to this Authorization is not a health care provider, health plan or healthcare clearinghouse, the information may be subject to disclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

This authorization will expire one year from the date of the signature below.

The information will be obtained and/or disclosed for the following reason(s):

◯ Treatment/ Continuity of Treatment	◯ Legal Reasons
◯ AT THE REQUEST OF THE INDIVIDUAL	◯ Assessment and Evaluation
◯ Other (specify) _____	

This authorization may be revoked by notifying our Privacy Officer in writing at the following address:

Jeff Erwin, AFCN Privacy Officer, Bryant Family Clinic, 507 W. Commerce, Bryant Ar., 72022

Phone: 501- 847-0082 Fax: 501-847-6680

NOTE: Protected health information may already have been disclosed before the revocation is received. If so the revocation will be effective only as of the date it is received by AFCN.

Patient signature: Date:

_____

If patient representative what is relationship or authority?

_____

This authorization is voluntary. A refusal to sign will not affect the patient's ability to obtain treatment, payment or, if applicable enrollment in a health plan or eligibility for benefits.

REVISED AUGUST 2016