

Regional Family Medicine

Please Circle Provider of Choice

***** MUST HAVE PHOTO ID (18 & Older) & INSURANCE CARDS TURNED IN WITH THESE FORMS *****

- J. Gregory Elders M.D.
 Michael S. Hagaman M.D.
 Ronald F. Bruton M.D.
 George S. Lawrence M.D.
 Lonnie S. Robinson M.D.
 Andrea N. Bounds M.D.
 Sharon Jamie Pritchard M.D.

PATIENT INFORMATION: (MUST BE COMPLETELY FILLED OUT)

Last Name: _____ First Name: _____ Middle Initial: _____

DOB:	Social Security #:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:
Address:	City:	State:	Zip:
Please Circle Preferred Contact Method		Home Phone:	Cell Phone:
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____ <input type="checkbox"/> Decline			
Ethnic Group: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Decline			
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
DL #:	DL Exp. Date:	State:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Spouse's Name:			
Patient's Employer:		Employer Phone:	
Spouse's Employer:		Employer Phone:	

RESPONSIBLE PARTY INFORMATION: (MUST BE COMPLETELY FILLED OUT)

<input type="checkbox"/> Check here if the Patient is the Responsible Party (Skip this Section)			
Relationship of Responsible Party to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Other _____			
Responsible Party:	DOB:	Social Security #:	
Home Phone:	Cell Phone:	Work Phone:	
Address:	City:	State:	Zip:
DL #:	DL Expiration Date:		

INSURANCE INFORMATION: (MUST BE COMPLETELY FILLED OUT)

(Please Present Insurance Cards to Receptionist)			
Primary Insurance Company:			
Name of Policy Holder:	Holder DOB:	Holder SS#:	
Insurance Policy #:	Group #:	Copay:	
If name of Patient is Different from the Policy Holders Please Indicate Relationship to Patient: <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____			
Secondary Insurance Company:			
Name of Policy Holder:	Policy Holder DOB:	Policy Holder SS#:	
Insurance Policy #:	Group #:	Copay:	
If name of Patient is Different from the Policy Holders Please Indicate Relationship to Patient: <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____			

EMERGENCY CONTACT INFORMATION: (MUST BE COMPLETELY FILLED OUT)

Emergency Contact Name:	Relationship:	DOB:	Phone:
Emergency Contact Name:	Relationship:	DOB:	Phone:
Emergency Contact Name:	Relationship:	DOB:	Phone:
<input type="checkbox"/> Please Check and Date that HIPAA Policy was received Date: _____			

Assignment of Benefits * Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to REGIONAL FAMILY MEDICINE, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all cost of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: (CHECK ALL THAT APPLY)

(MUST BE COMPLETELY FILLED OUT)

- | | | |
|---|---|---|
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> GERD | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GI Disease _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Back pain | | |

FEMALES: Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gestational Age: _____ weeks	Planning to Become Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
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SURGICAL HISTORY:

Procedure/Operation	Year

FAMILY HISTORY:

Please include medical problems like Heart Attack, High Blood Pressure, Diabetes, Cancer, etc., and any hereditary conditions

Father	
Mother	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	
Siblings	
Children	

DRUG ALLERGIES:

Please list medications you are allergic to including the reaction type i.e. rash, itching, swelling, etc. If you do not have any allergies please state NONE.

CURRENT MEDICATIONS: (Including Over the Counter and As Needed medications)

Name of Medication	Strength	Frequency

Preferred Pharmacy: _____ City: _____ State: _____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

(MUST BE COMPLETELY FILLED OUT)

TOBACCO USAGE:

Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	Packs per Day?	How long?	If you quit, when?
Do you use smokeless tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	Cans per Day?	How long?	If you quit, when?

Are you interested in quitting tobacco products? Yes No

ALCOHOL USAGE:

Do you drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type?	How Much?	How Often?
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DRUG USAGE:

Do you use or abuse illegal or prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type?	How Often?
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BIRTH HISTORY: (PLEASE ANSWER THIS PORTION IF THE PATIENT IS 0-18 YEARS OLD)

Birth Weight: _____ lbs _____ oz Gestational Age at Birth: _____ weeks
Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean If Cesarean, Why?
Was baby healthy at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No, If no please explain:
Did mother have any illness or problems during pregnancy?
Tobacco use during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No Drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No, If yes what drugs?
Did baby go home from the hospital with mother? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:

PREVENTION HISTORY:

When was your last Flu Vaccine?
When was your last; Pneumonia Vaccine What type and when? <input type="checkbox"/> Pevnar 13 <input type="checkbox"/> Pneumovax 23
When was your last; COVID-19 Vaccine Shingles Vaccine
When was your last Tetanus Vaccine?
Have you ever had a colonoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when was most recent? Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
FEMALES ONLY:
Have you ever had a pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when was most recent? Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when was most recent? Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No

REGIONAL FAMILY MEDICINE

630 BURNETT DRIVE MOUNTAIN HOME, AR 72653

630 Burnett Drive
Mountain Home, AR 72653
PH: 870-425-6971 Fx: 870-508-8900

250 Drillers Road
Mountain Home, AR 72653
PH: 870-492-5995 Fx: 870-508-8900

J. Gregory Elders, MD ♦ George S. Lawrence, MD ♦ Lonnie S. Robinson, MD ♦ Andrea N. Bounds, MD
Michael S. Hagaman, MD ♦ Ronald F. Bruton, MD ♦ Sharon Jamie Pritchard, MD

Date: _____

Patient's Name: _____

I _____ authorized permission to **discuss and/or release** medical information to the following people. **PLEASE FILL OUT NAMES BELOW**

_____ (Name)	_____ Relationship to Patient	_____ Phone Number
_____ (Name)	_____ Relationship to Patient	_____ Phone Number
_____ (Name)	_____ Relationship to Patient	_____ Phone Number
_____ (Name)	_____ Relationship to Patient	_____ Phone Number

EMERGENCY CONTACT INFO:

_____ Name	_____ Relationship	_____ Phone
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PATIENT'S E-MAIL ADDRESS _____

E-MAIL RISK AND YOUR RESPONSIBILITY

Regional Family Medicine (RFM) may use e-mail to communicate with you. These e-mails may contain your/your family member's personal health information. If you agree to permit RFM to use e-mail to communicate with you, you should be aware of the following risks and/or **your** responsibilities:

- The internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify e-mails you send or are sent by RFM.
- The patient's personal information is required to ensure correct identification. (legal name and DOB)
- Be careful in the wording of your e-mail so the information is clear and describes the information you intend to convey and show consideration for sensitive medical information such as sexually transmitted diseases, mental health, disabilities, or substance abuse.
- You are responsible to make sure the information you provide is correct.

CONDITIONS FOR THE USE OF E-MAIL

By consenting to the use of e-mail with RFM you agree that:

- RFM may forward e-mail as appropriate for diagnosis, treatment, reimbursement, and other reasons related to your health care. RFM employees, other than the recipient may have access to e-mails that you send.
- RFM will not forward e-mails to independent third parties without your prior written consent, unless authorized or required by law.
- RFM will make every effort to respond promptly to your email but may not always be able to do so. If your e-mail requires or ask for a response and you have not received a response within a 24 hour time period. It is your responsibility to follow up directly with RFM.
- E-mails are not the only form of communicating that RFM will use to communicate with you and RFM may decide that it is not in you or your family member's best interest to continue communicating with you via e-mail.
- If you wish to discontinue communicating via e-mail you must do so in writing, not via e-mail.

ACKNOWLEDGMENT AND AGREEMENT

- RFM will use reasonable means to protect the privacy of the patient's health information. However, due to the risks mentioned above RFM will not be liable for improper disclosure of any health information that is **not** caused by RFM's intentional misconduct.

By signing below, I acknowledge that I have read and understand this consent form and understand the risk associated with the communications of e-mail between RFM and myself, and the conditions outlined herein, as well as any other instructions that RFM may impose to communicate with me by e-mail. I understand that this consent is valid until such time as I revoke the consent as outlined above.

Signature of Patient/Legal Guardian: _____ Date: _____

RFM Representative Signature: _____ Date: _____

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I Have Received The Privacy Notice

HIPAA

Patient's Signature Date

(Print Patient's Name)

_____ For _____
(Guardian's Name) (Patient's Name)

Patient has refused to sign form

____ / ____ / ____
(Date of Refusal)

Please be advised that Regional Family Medicine now posts your medical information to the Central Arkansas SHARE Database for use by emergency medical providers and other medical providers. This information is subject to the same privacy rules as our office.

Participation in this database is required by the HITECH Act of 2009, but you have the right to opt out. Please notify an employee of Regional Family Medicine, if you wish to stop your information from being stored.

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Welcome to Regional Family Medicine!

We want to thank you for choosing us for your primary healthcare provider. As a Patient Centered Medical Home, Regional Family Medicine strives to be your first point of contact in the healthcare system. We hope your experience with our team exceeds your expectations.

We want you to be aware of our various services and the numerous ways you can connect with your healthcare team. We provide 24/7/365 care, from our regular office hours of 8:00 am to 5:00 pm Monday – Friday to our Saturday clinic starting at 9:00 am.

Outside of regular and extended office hours, we also provide access to on-call doctors who will get back to you promptly for your after-hours needs, **No matter when you may need our assistance, there is only one number you need to remember... call our Main Office phone at: (870) 425-6971.**

We are also on the web at www.rfmmh.com here you can see our two convenient locations and get more information on the many services we offer our patients including an in house lab and radiology department. On the patient forms and info tab you can also get information on our Patient Portal. After successfully registering for the patient portal, you can then access your medical records and connect with our staff electronically.

Below is a list of our providers and their extension numbers if you have any questions for your provider.

Main Branch

J. Gregory Elders, MD (870) 425-6971 ext. 8937	Andrea N. Bounds, MD (870) 425-6971 ext 8942
George S. Lawrence, MD (870) 425-6971 ext. 8974	Meredith Gaines, CNP and Mary Burr, CNP (870) 425-6971 ext. 8933
Lonnie S. Robinson, MD (870) 425-6971 ext. 8976	Sally Hambelton, CNP (870) 425-6971 ext. 8955

East Branch

Michael S. Hagaman, MD (870) 492-5995 ext. 7986	Ronald F. Bruton, MD (870) 492-5995 ext. 7988
Sharon Jamie Pritchard, MD (870) 492-5995 ext. 7993	

We hope you feel welcome to your new medical home: Regional Family Medicine. Please feel free to contact your provider team if you have more specific needs or questions.

Sincerely,

Regional Family Medicine

**J. Gregory Elders, MD ♦ George S. Lawrence, MD ♦ Lonnie S. Robinson, MD ♦ Andrea N. Bounds, MD
Michael S. Hagaman, MD ♦ Ronald F. Bruton, MD ♦ Sharon Jamie Pritchard, MD**

NEW PATIENTS

***** MUST BRING PATIENT'S PHOTO ID (18 & older) & INSURANCE CARDS WITH THIS FORM *****

PLEASE CIRCLE THE NAME OF THE DOCTOR YOU WOULD LIKE TO SEE

Dr. Elders Dr. Hagaman Dr. Bruton Dr. Lawrence
Dr. Robinson Dr. Bounds Dr. Pritchard

Patient Name: _____ / _____
(Name of parent or guardian)

Date of Birth: _____ Social Security Number: _____

Patient's COMPLETE mailing Address: _____

Daytime Phone Number: _____

Medications: _____

Controlled Substance (Rx): _____

Medical Issues: _____

Insurance Info: _____

Do you have family members established with one of our doctors? YES NO

If yes list names of family members _____

Are you already established with another provider?

Who? _____ Where? _____

Have you been a patient of Regional Family Medicine in the past? If so who was your Provider? _____

Date: _____ Received by Staff Member: _____