NEW PATIENTS

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

PLEASE CHECK BY THE NAME OF THE DOCTOR YOU WOULD LIKE TO SEE

☐ J. Gregory Elders M.D. ☐ George S. Lawrence M.D. ☐ Lonnie S. Robinson M.D. ☐ Andrea N. Bounds M.D.

☐ Ronald F. Bruton M.D. ☐ Sharon Jamie Pritchard M.D. ☐ Alex S. Hagaman D.O. ☐ Hannah G. McCarthy M.D.

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

Date: _____ Received by Staff Member:_____

Regional Family Medicine

Please Circle Provider of Choice

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

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□ Ronald F. Bruton M.D. □ Sharon Jamie Pritchard M.D. □ Alex S. Hagaman D.O. □ Hannah G. McCarthy M.D.

Patient Information: (MUST BE COMPLETELY FILLED OUT)

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

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

Responsible Party Information: (MUST BE COMPLETELY FILLED OUT)

□ Check here if the Patient is the Responsible Party (Skip this Section)			
Relationship of Responsible Party to Patient: □Spouse □Parent/Guardian □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:	**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: □Child □Spouse □Other_____		
Secondary 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: □Child □Spouse □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:**
□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)

- ☐ Dizziness/Vertigo
- ☐ Headache
- ☐ Seizures
- ☐ Stroke
- ☐ Seasonal Allergies
- ☐ Thyroid Disease
- ☐ COPD
- ☐ Asthma
- ☐ Back pain
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Heart murmur
- ☐ Heart Palpitations
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ GERD
- ☐ GI Disease_____
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ Mental Illness_____
- ☐ Cancer_____
- ☐ Other_____

Females: **Are you Pregnant?** ☐Yes ☐No **Gestational Age:**_____ weeks **Planning to Become Pregnant?** ☐Yes ☐No

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? ☐Yes ☐No	Packs per Day?	How long?	If you quit, when?
Do you use smokeless tobacco ☐Yes ☐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? ☐Yes ☐No	Type?	How Much?	How Often?

DRUG USAGE:

Do you use or abuse illegal or prescription drugs? ☐Yes ☐No	Type?	How Often?

BIRTH HISTORY: (PLEASE ANSWER THIS PORTION IF THE PATIENT IS 0-18 YEARS OLD)

Birth Weight: _____lbs _____oz **Gestational Age at Birth: _____** weeks
Delivery: ☐Vaginal ☐Cesarean **If Cesarean, Why?**
Was baby healthy at birth? ☐Yes ☐No, **If no please explain:**
Did mother have any illness or problems during pregnancy?
Tobacco use during pregnancy? ☐Yes ☐No **Alcohol use?** ☐Yes ☐No **Drug use?** ☐Yes ☐No, **If yes what drugs?**
Did baby go home from the hospital with mother? ☐Yes ☐No **Explain:**

PREVENTION HISTORY:

When was your last Flu Vaccine?
When was your last; Pneumonia Vaccine **What type and when?** ☐Prevnar 13 ☐Pneumovax 23 **When was your last;** COVID-19 Vaccine Shingles Vaccine
When was your last Tetanus Vaccine?
Have you ever had a colonoscopy? ☐Yes ☐No **If so, when was most recent?** **Was it normal?** ☐Yes ☐No
FEMALES ONLY:
Have you ever had a pap smear? ☐Yes ☐No **If so, when was most recent?** **Was it normal?** ☐Yes ☐No
Have you ever had a mammogram? ☐Yes ☐No **If so, when was most recent?** **Was it normal?** ☐Yes ☐No

REGIONAL FAMILY MEDICINE

630 BURNETT DRIVE MOUNTAIN HOME, AR 72653

PH: 870-425-6971 Fx: 870-508-8900

J. Gregory Elders, M.D. George S. Lawrence, M.D. Lonnie S. Robinson, M.D. Andrea N. Bounds, M.D.
Ronald F. Bruton, M.D. Sharon Jamie Pritchard, M.D. Alex S. Hagaman, D.O. Hannah G. McCarthy, M.D.

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

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:

a. 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.
b. The patient's personal information is required to ensure correct identification. (legal name and DOB)
c. 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.
d. 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:

a. 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.
b. RFM will not forward e-mails to independent third parties without your prior written consent, unless authorized or required by law.
c. 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.
d. 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.
e. If you wish to discontinue communicating via e-mail you must do so in writing, not via e-mail.

ACKNOWLEDGMENT AND AGREEMENT

a. 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

_____ _____
Patients Signature **Date**

_____
(Print Patient's Name)

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

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.

* Regional Family Medicine is a member of an ACO (Accountable Care Organization). This organization is set forth to get patient centered care focusing on YOUR needs. They help gather information to enable your health care providers see the same test results, treatments, and prescriptions. The ACO can also aid in preventing medical errors and drug interactions. This can help you to save money and time by avoiding repeated test and appointments.
Better communication can help protect against Medicare fraud.

☐ Patient has refused to sign form
____ / ____ / ____
(Date of Refusal)

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

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

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
George S. Lawrence, MD (870) 425-6971 ext. 8974
Michelle Sharp, CNP (870) 425-6971 ext. 8933
Andrea N. Bounds, MD (870) 425-6971 ext 8942
Lonnie S. Robinson, MD (870) 425-6971 ext. 8976
Hannah Caststeel, CNP (870) 425-6971 ext 8933

East Branch

Ronald F. Bruton, MD (870) 492-5995 ext. 7988
Alex Hagaman, DO (870) 492-5995 ext 7993
Sharon Jamie Pritchard, MD (870) 492-5995 ext. 7993
Hannah McCarthy, 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