SALEM FAMILY
PRACTICE CLINIC
PATRICIA MCGARRY, M.D.

6640 Congo Road Benton, AR 72019 PH: (501) 794-4110 FAX: (501) 316-9360

Minor Patient Registration Information

Patient's Personal Information

Name: _____ SS#: ____ - ____ -_____ Date of Birth: __ / __ / ____
Last First MI

Sex: M / F Primary phone #: (_____)_____ Alternate phone #: (_____)_____

Primary E-mail:_____

Child's Primary Address: _____ City: _____ State:_____ Zip:_____

Mother or Parent One Name:_____ Cell Phone #: (_____)_____ SS#:_____-_____-_____

Father or Parent Two Name:_____ Cell Phone #: (_____)_____ SS#:_____-_____-_____

Race: ☐ White ☐ African American ☐ Asian ☐ Other ☐ Native American Indian/Alaskan ☐ Decline to answer ☐ Native Hawaiian/Other Pacific Islander

Ethnic Group: ☐ Not Hispanic/ Latino ☐ Hispanic/Latino ☐ Decline to answer

Primary Language: ☐ English ☐ Spanish ☐ Other

Emergency Contact—Please list someone that would not be with child

Name:_____ Relationship:_____

Best Phone: (___)_____ Alternate Phone: (___)_____

Preferred Pharmacy

Name: _____

Phone #:_____

Guarantor Information (Person responsible for child's bills)

Relationship to patient: ☐ Father ☐ Mother ☐ Other_____

Name: _____ SS#: ____ - ____ -_____ DL#: _____
Last First MI

Date of Birth: ___ / ___ / ____ Main phone#: (___)_____ Alternate phone: (___)_____

Address: _____ Apt#: _____ City: _____ State:_____ Zip:_____

Employer:_____ Work phone: (___)_____ Occupation:_____

Patient's Insurance Information

Primary Insurance Company: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____ Main phone#: (___)_____

Subscriber's relationship to patient: ☐ Self ☐ Father ☐ Mother ☐ Other_____ Copay: $_____

Secondary Insurance Company: _____ ID#: _____ Group#: _____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____ Main phone#: (___)_____

Subscriber's relationship to patient: ☐ Self ☐ Father ☐ Mother ☐ Other_____ Copay: $_____

I request that payment of authorized insurance benefits be made on my child's behalf to the provider indicated above for services furnished to my child. I authorize any holder of medical information about my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (The parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce situation must be dealt with between those parties and does not involve.)

_____ _____
Parent/Legal Guardian Signature Date

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BENTON, AR 72019

Salem Family Practice Clinic, P.A. is dedicated to providing you fast and reliable information concerning your care. In many cases, we may not be able to talk to you directly because you may be away from your telephone. A convenient alternative is to leave you a message for you to check later at your convenience. However, these messages may contain confidential issues.

Please indicate the best way for us to contact you and leave a detailed message.

I (patient's name)_____ authorize the staff of Salem Family Practice Clinic, P.A. to leave and transmit confidential information to one or more of the following:

( ) **Answering machine** at the home telephone number ( ) _____-_____.

( ) **Voice mail** at the work number ( ) _____-_____ ***but only*** if the voice mail has your name.

( ) **Voice mail** at the cell number ( ) _____-_____ .

IN ORDER FOR ANYONE, OTHER THAN YOURSELF, TO RECEIVE ANY OF YOUR MEDICAL INFORMATION, PLEASE FILL OUT THE PORTION BELOW

I (patient's name) _____ authorize Salem Family Practice Clinic, P.A. to share "Protected Health Information' with my family members or significant others, as noted below:

1. Name: _____ Relationship: _____ Phone Number: ( ) _____-_____
2. Name: _____ Relationship: _____ Phone Number: ( ) _____-_____
3. Name: _____ Relationship: _____ Phone Number: ( ) _____-_____

I understand that I may withdraw the above authorization at any time, with written request. I also understand that it is my responsibility to inform all family members or significant others to not to disclose any information at any time or in any way without my written permission.

My signature below also acknowledges a copy of the Patient Privacy Practices Notice was received (but NOT necessarily read).

Patient OR Guardian Signature_____Date_____

SALEM FAMILY PRACTICE CLINIC
OFFICE POLICIES

MISSED APPOINTMENTS

If you are a new patient and miss your first visit, we will not reschedule.

Three (3) missed, no-show appointments will result in dismissal from the practice.

There will be a $25 charge for a missed appointment.

We understand appointments sometimes need to be changed, so we ask that you please call our office in advance if you cannot keep your scheduled appointment.

PHONE CALLS

Please allow up to 24 hours to receive a phone call back.

Usually all phone calls are returned the same business day. Phone calls after 4:30pm are returned the next day.

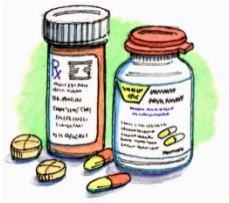
LAB WORK

For the convenience of the patients and the staff here at Salem Family Practice, <u>we will call to provide the results only if there is a problem.</u>
If you would like a copy of your lab results you may bring in a stamped self-addressed envelope with you to your appointment and once the results come in we will mail you the results OR you may stop in our office to pick up a copy at your convenience.

WE CAN NOT ACCEPT LAB ORDERS FROM OTHER DOCTORS OR FACILITIES

MEDICATION REFILLS

For refills on medications please call your pharmacy first.



MEDICATIONS

Salem Family Practice Clinic does **not** offer chronic pain management and will **not** prescribe chronic pain medications. For example, daily chronic narcotics or Xanax. We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by Dr. McGarry.

Here at Salem Family Practice we participate in the **Arkansas Drug Monitoring Program**. This program provides complete and detailed reports of all prescriptions that each and every patient receives at their pharmacy or pharmacies. The goal of this program is to enhance patient care and ensure legitimate use of controlled substances.

I have read and agreed to Salem Family Practice's office polices listed above:

Patient Signature: _____ Today's Date: _____

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

Allergies

_____

_____

_____

_____

_____

Health History

Family History

Fill in health information about your immediat nily.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Patient Name: _____ Patient DOB: ___/___/_____ Date: ___/___/_____

Wellness Update

Do you experience any of these symptoms?	*Yes*	*No*
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ Yes ☐ No

If yes, name of medication and last date taken: _____

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Migraine Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc...)

Patient/Guardian Signature: _____ **Date:** ___/___/_____

Patient Phone: _____

FOR PROVIDER USE ONLY:
Order Allergy Test: ☐ Yes ☐ No
Date of last ENT exam: ___/___/_____

Provider Signature: _____ **Date:** ___/___/_____

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DR. PATRICIA MCGARRY, M.D. |PH: (501) 794-4110
6640 CONGO ROAD BENTON, AR 72019 | FAX: (501) 316-9360

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Information:

Name: _____ DOB: _____/_____/_____
Address: Street_____ City: _____
State: _____ Zip: _____ Social Security #:_____-_____-_____

I authorize to release my medical records to or from the following:

Name or Facility: _____ Ph. #:_____
Address: _____ Fax #:_____

This Request and authorization applies to (check one):

- ○ Healthcare information relating to the following treatment, condition or dates:

  _____
- ○ All healthcare information
- ○ Other: _____

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., included herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient's Signature: _____ Date Signed: _____