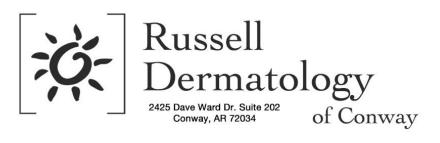


Appt Date:
Appt Time:
Provider:
Reason for Visit:

NAME:		DATE OF BIRTH:	GENDER:			
		SSN:				
ADDRESS:						
PHARMACY:		PRIMARY CARE PHYSICIAN:				
EMERGENCY CONTACT: _		PHONE :				
PRIMARY INSURANCE:		SECONDARY INSURANCE:				
PLEASE BRING ALL	INSURANCE CARDS	S AND IDENTIFICATION TO	YOUR APPOINTMENT.			
If you are unsure if your in	surance is in our netw	vork, please contact our offic	ce at 501-328-5050, ext. 309.			
I HEARBY AUTHORIZE RU RECORDS TO THE BELOW		BY TO RELEASE OR DISCLOS	SE ALL MY MEDICAL			
NAME:		RELATIONSHIP:				
		RELATIONSHIP:				
		RELATIONSHIP:				
This author	rization will remain in	effect until you submit a cha	nge in writing.			
YOUR BEHALF? IF SO, PLI	EASE LIST THEM BEL	WOULD LIKE US TO REQUE OW: CITY/S'				
A separate form	will be provided to you	u requesting permission to a	ttain these records.			
		'S BALANCE/CHARGES INC /IDE THE RESPONSIBLE PEI				
STREET ADDRESS/CITY/ST	ATE/ZIP:					
carrier processes the claim. All not covered by the patient's incompany for testing. This will pwill be the patient's responsible Missed appointments without 2 to complete and process information.	Il copays and deductibles surance will be the patien or oduce a separate charge bility. Depending on your in 24-hour notice will be chair mation required by cancer paid for at the time of serv	t's responsibility. <u>All</u> biopsies/prod that will be filed with your insuran nsurance, this separate charge cou ged a fee of \$50.00. A charge of \$2 or similar types of insurance polic	Any deductible, copay, or balance edures will be sent to a pathology ce. Any cost not paid by insurance			
X	X					
Patient Signature	Witnes	s Signature	Date			



Appt Date:	
Appt Time:	
Provider:	-
Reason for Visit:	-

## **MEDICAL HISTORY**

	MEDICALI	IIISIONI			
PATIENT NAME:	NT NAME: DATE OF BIRTH:				
<b>MEDICATION ALLERGIES</b>	:				
	:				
	DO YOU HAVE ANY OF THE F				
ASTHMA		HYPERTENSION			
ATRIAL FIBRILLATION		HYPERTHYRODISM			
DEPRESSION	HEPATITIS (B or C)	SEIZURES	)		
DIABETES	HIV/AIDS	STROKES			
	HAVE YOU HAD ANY OF THE	FOLLOWING SURGERIES?			
HEART VALVE	CORONARY BYPASS	HIP REPLACEMENT ( R / L )	HYSTERECTOMY		
REPLACEMENT		KNEE REPLACEMENT ( R /			
	SKIN DISEAS	F HISTORY:			
ACTINIC KERATOSES	DRY SKIN				
	BASAL CELL _				
	SQUAMOUS CELL				
DO YOU WEAR SUNSCREE	NO / YES SPF:	TANNING BED USE?	NO / YES		
DO YOU HAVE A FAMILY H	ISTORY OF MELANOMA? NO	/ YES IF YES, RELATION:			
	SOCIAL H	ISTORY:			
SMOKING STATUS: CI	URRENT FORMER NE	EVER			
	ONE 1 OR LESS PER DAY		ORF PFR DAY		
	LIST PREVIOUS OCCUPATION				
VACCINATION RECORDS	•	(65 AND OLDER)			
PNEUMONIA VACCINE: NO / YES		DO YOU HAVE A HEALTHC	ΔRF		
FLU VACCINE: NO / YES		PROXY? NO / YES	AIL		
COVID VACCINE: NO /	IES	PROXY: DO YOU HAVE A LIVING W			
	ARE YOU EXPERIENCING A				
PROBLEMS WITH BLEEDIN	IG — NIGHT SWEATS	NAUSEA	NECK STIFFNESS		
PROBLEMS WITH HEALING	UNPLANNED WEIGHTLOS  ANXIETY	SS VOMITING DIARRHEA	HEADACHES SEIZURES		
PROBLEMS WITH SCARRIN	NG — ANAIETT  DEPRESSION	ABDOMINAL PAIN	COUGH		
RASH	THYOID PROBLEMS	BLOODY STOOL	SHORTNESS OF BREATH		
IMMUNOSUPPRESSION	SORE THROAT	BLOODY URINE	WHEEZING		
HAY FEVER	DRY, ITCHY EYES	JOINT ACHES	CHEST PAIN		
FEVER/CHILLS	BLURRY VISION	MUSCLE WEAKNESS	<del></del>		
X					
Patient Signature		Date			