Dr. Andy's Family Practice Clinic, PLLC

1809 Ozarka College Dr.
PO Box 1198
Mountain View, AR 72560
Phone: (870) 269-7777 Fax: (870) 269-5055

Reason for Visit:

Patient Name (Last, First, Middle)	☐ Jr ☐ Sr ☐ I ☐ II ☐ III ☐ IV	Maiden Name	Social Security Number / /

Date of Birth / /	Sex ☐ Male ☐ Female	Age	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Mailing Address	City, State	Zip Code

Home Phone #	Cell Phone #	Patient Email

Former Primary Care Physician	Physician Phone #	Race	Ethnicity ☐ Hispanic ☐ Non-Hispanic	Preferred Language (Specify)

Guarantor

Guarantor Name	Date of Birth / /	Social Security Number / /	Relationship to Patient	Sex	Age

Mailing Address	City, State	Zip Code

Home Phone	Cell Phone	Occupation	Employer	Employer Phone

Emergency Contact

Name	Home Phone	Cell Phone	Work Phone

Relationship to Patient	Comments

Primary Insurance

Insurance Company Name	
Address	
City, State	Zip Code
Phone #	Effective Date
Policy/ID #	Group
Patient's Relationship to Subscriber	
Subscriber's Name	
Subscriber's Employer	Employer Phone #

Secondary Insurance

Insurance Company Name	
Address	
City, State	Zip Code
Rhone #	Effective Date
Policy/ID #	Group
Patient's Relationship to Subscriber	
Subscriber's Name	
Subscriber's Employer	Employer Phone #

Authorization to release insurance information: I hereby authorize the release of medical information to my insurance company/companies concerning my healthcare.

Signed_____ Date _____

Authorization for assignment of medical payments: I hereby authorize payment of any medical benefits to Dr. Andy's Family Practice, PLLC.

Signed_____ Date _____

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Pharmacy:
Allergies:

Does the patient have any of the following health conditions? Check all that apply:

Disease or Illness	✓	Disease or Illness	✓
Heart Disease (Specify: _____)		Liver Problems (Specify: _____)	
Circulatory Problems (Specify: _____)		Hypothyroidism	
Congestive Heart Failure		Hyperthyroidism	
High Blood Pressure		Sleep Apnea (☐ C-Pap ☐ Bi-Pap)	
High Cholesterol		Blood Disorders (Specify: _____)	
Stroke		Hepatitis (Specify:_____)	
Asthma		Diabetes Type 1	
Emphysema		Diabetes Type 2	
Chronic Obstructive Pulmonary Disease (COPD)		Gout	
Acid Reflux		Arthritis	
Ulcers		Osteoporosis	
Cancer (Specify: _____)		Migraines	
Kidney Stones		Seizures	
Kidney Failure		Other (Specify: _____)	

Are you: ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Employed
Do you have children? ☐ Yes ☐ No If yes, how many?
Do you have any mental disorders such as Depression, Anxiety, Bipolar, PTSD, etc.? ☐ Yes ☐ No If yes, specify:
Do you have any communicable diseases such as STD's, Tuberculosis, etc.? ☐ Yes ☐ No If yes, specify:
Do you use tobacco products? ☐ Yes ☐ No ☐ Former Use (Approx quit date: _____) If yes, do you use: ☐ Smokeless ☐ Cigars ☐ Cigarettes ☐ Vape If yes, how much/how often?
Do you drink alcohol? ☐ Yes ☐ No ☐ Former Use (Approx quit date: _____) If yes, how much? How often? What do you drink?
Do you drink caffeine? ☐ Yes ☐ No ☐ Former Use (Approx quit date: _____) If yes, how much? How often? What do you drink?
Do you currently use/have you ever used any illegal and/or recreational substances? ☐ Yes ☐ No ☐ Former Use (Approx quit date: _____) If yes, what substances and how often did you use them? _____ _____

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PROCEDURES/TESTS/VACCINES:

Test	Date(s)	Results
Colonoscopy		
Endoscopy		
Stress Test (Nuclear/Exercise)		
Echocardiogram		
Carotid Doppler		
Bone Density		
Mammogram		
Pap Smear		
Sleep Study		
Eye Exam		
Influenza Vaccine		
Pneumonia Vaccine		
Tetanus Vaccine		
Shingles Vaccine		
Covid-19 Vaccine		
Other Vaccines (Specify)		

SURGERIES:

Please list any surgeries below, including dates (can be an estimate).

Example: *Tonsillectomy: April 1985*

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MEDICATIONS:

Please include ***ALL*** prescription, over-the-counter medications, vitamins, supplements, etc.

Medication Name	**Dose**	**Frequency**
Example: *Any Medicine*	*20mg*	*1 daily*

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FAMILY HISTORY:

Does any of your ***family members*** have any of the following health conditions? Check all that apply:

Disease or Illness	**Mom**	**Dad**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Sister**	**Brother**
Heart Disease (Specify: _____)								
Circulatory Problems (Specify: _____)								
Congestive Heart Failure								
High Blood Pressure								
High Cholesterol								
Hypothyroidism								
Hyperthyroidism								
Asthma								
COPD								
Emphysema								
Sleep Apnea								
Liver Problems (Specify: _____)								
Hepatitis (Specify: _____)								
Blood Disorders (Specify: _____)								
Migraines								
Stroke								
Epilepsy								
Seizures (Specify: _____)								
Kidney Stones								
Kidney Failure								
Acid Reflux								
Ulcers								
Gout								
Arthritis								
Osteoporosis								
Type 1 Diabetes								
Type 2 Diabetes								
Cancer (Specify: _____)								
Drug Addiction (Specify: _____)								
Alcoholism								

HIPAA PRIVACY
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:		
Patient Name:		
Address, City, State, Zip:		
Person/Organization Providing the Information from:		
Dr. Andy's Family Practice, PLLC **1809 Ozarka College Dr** **P.O. Box 1198** **Mountain View, AR 72560**		
Person/Organization Releasing the Information to:		
Name	**Phone #**	**Relationship to the Patient**

This authorization for release of the above information to the above-named persons/organizations will expire one year from the date of signature or on _____.

I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand I have the right to receive a copy of this authorization.

_____ _____

Signature of Patient Today's Date