Benton Family Clinic

Baptist Health

Full Name:			Social Security Number:	
Date of Birth:	Age:		Marital Status:	
Legal Sex: ▢ Male ▢ Female	Sex assigned at birth: ▢ Male ▢ Female ▢ Decline to Report			
Address:	City:	State:	Zip Code:	
Race (Select all that apply): ▢ American Indian and Alaska Native ▢ Asian ▢ Black or African American ▢ White or Caucasian ▢ Native Hawaiian or Other Pacific Islander ▢ Other ▢ Unknown ▢ Decline to Report				
Ethnicity (Select one): ▢ Non-Hispanic ▢ Hispanic ▢ Unknown ▢ Decline to Report				
Gender Identity: ▢ Male ▢ Female ▢ Transgender Female ▢ Transgender Male ▢ Other ▢ Decline to Report				
Sexual Orientation: ▢ Straight ▢ Lesbian or Gay ▢ Bisexual ▢ Something else ▢ Decline to Report				
Preferred Language:	Do you need an interpreter? ▢ Yes ▢ No			
Phone:	Cell:	Email:		
Preferred Method of Contact (Select all that apply): ▢ MyChart ▢ Phone ▢ Email ▢ Text Message ▢ Mail				
Employment Status: ▢ Full Time ▢ Part Time ▢ Not Employed ▢ Retired ▢ Student ▢ Homemaker ▢ Decline to Report				
Highest level of schooling you have received: ▢ Not a high school graduate ▢ GED ▢ High school graduate ▢ Some college ▢ Associate's Degree ▢ Bachelor's Degree ▢ Master's Degree ▢ Doctorate or Professional Degree ▢ Decline to Report				
Pharmacy:	Previous Primary Care Physician:			
Employer:	Work Phone:			

EMERGENCY CONTACT

Name:	Relationship:	Phone:	Cell:	
Address:	City:	State:	Zip Code:	**Approved HIPAA Contact?** ▢ **YES** ▢ **NO**

GUARANTOR INFORMATION (Person/Entity financially responsible for the patient)

Name:		Relationship:	
Social Security Number:	Date of Birth:		Phone:
Address:	City:	State:	Zip Code:
Employer:	Work Phone:		

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Mail Claims To:	Mail Claims To:
Group No.: ID No.:	Group No.: ID No.:
Subscriber's Name:	Subscriber's Name:
Relationship to patient:	Relationship to patient:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's Employer:	Subscriber's Employer:

AUTHORIZATION TO TREAT MY CHILD (if applicable)

List below any persons that you give permission to accompany your child for medical treatment (other than parent or guardian):

Name:	Relationship to You:	Telephone Number:	
			▢ **Approved HIPAA Contact?**
			▢ **Approved HIPAA Contact?**

AUTHORIZATION, CONSENT, AND ACKNOWLEDGEMENT

I hereby authorize my insurance benefits to be paid directly to Benton Family Clinic. I consent to the use or disclosure of my protected health information by Benton Family Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Benton Family Clinic have the right to revoke this consent in writing at any time, except to the extent that Benton Family Clinic has taken action in reliance on this consent. The Notice of Privacy Practices for Benton Family Clinic has been provided to me.

_____ _____

Signature of Patient or Guardian Date

Baptist Health Staff: This form should not be altered in any way. Please contact laura.lawrence@practice-plus.com to access the electronic copy of this form.

Benton Family Clinic

Patient Name: _____ **DOB:** _____ **Male or Female**

MEDICAL HISTORY: **Please check all diagnoses that apply to you and add notes as needed.**

	YES	NO		YES	NO
ADD/ADHD			Inflammatory Bowel Disease		
Allergies			Kidney Disease		
Anemia			Myocardial Infarction		
Anxiety			Narcolepsy		
Arthritis			Nerve, Muscle Disease		
Asthma			Obesity		
Cancer			Osteoporosis		
Cataracts			Restless Leg		
CHF			Seizures		
Clotting Disorder			Sickle Cell Anemia		
COPD			Sleep Apnea		
Depression			Stroke		
Diabetes Mellitus			Substance Abuse		
Eating Disorder			Thyroid Disease		
GERD			Ulcer		
Glaucoma			Vision Problems		
Headaches			Other Conditions:		
Heart Murmur					
Hepatitis					
High Cholesterol			_____		
HIV/AIDS			_____		
Hypertension					

SURGICAL HISTORY: Please check all that apply to you and add additional information below.

	YES	NO		YES	NO
Adenoidectomy			Hernia Repair		
Appendectomy			Hysterectomy		
Brain Surgery			Mastectomy		
CABG			Prostate Surgery		
Cholecystectomy			Spine Surgery		
Colon Surgery			Tonsillectomy		
Cosmetic Surgery			Tubal Ligation		
C-Section			Valve Replacement		
Orthopedic Surgery			Vasectomy		
Heart Surgery			Other:		
If you answered YES to any of the questions above please provide: Year, Hospital/Location, and/or Complications					

CURRENT MEDICATION(S):

Medication	Dose	Medication	Dose

ALLERGIC OR ADVERSE REACTION TO MEDICATION: (List medication, dosage, and reaction)

_____

_____

Benton Family Clinic

Family History:	Alcohol/Drug Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Early Death	Hearing loss	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Malig Hypertherm	Mental Illness	Miscarriage	Stroke	Vision Loss
Mother																				
Father																				
Brother																				
Sister																				
Maternal GM																				
Maternal GF																				
Paternal GM																				
Paternal GF																				

SOCIAL HISTORY: Whom do you live with? _____
Do you have children? If so, what are their names and age(s) _____

PLEASE CHECK ONE:

[ ] Never smoked cigarettes
[ ] Former smoker How many packs per day? _____ For how many years? _____
[ ] Current smoker How many packs per day? _____ For how many years? _____

Do or did you ever smoke cigars, e-cigarettes, pipes or chew tobacco? **[ ] Yes [ ] No** Quit? **[ ] Yes [ ] No**
Do you drink alcohol? **[ ] Yes [ ] No** How much alcohol do you drink in an average week? _____
Have you quit drinking? **[ ] Yes [ ] N**o If so, when did you quit? _____ How much did you drink per week? _____
Do you now or did you ever used street drugs (LSD, Cocaine, marijuana, meth, IV drugs)? **[ ] Yes [ ] No** Quit? **Yes No**

ADVANCED DIRECTIVE:
Do you have a Living Will/DNR? **[ ] Yes [ ] No** (if yes, please provide a copy for our records)
Do you have a Durable Power of Attorney? **[ ] Yes [ ] No**
If yes: _____
Please Print Name Phone Number
Would you like information regarding Advanced Directive? **[ ] Yes [ ] No**

HEALTH MAINTENANCE: Please indicate whether you have had the following screening tests and/or immunizations and the approximate date the most recent test or immunization(s) was done.

Screening Test	Yes	No	Approx. Date last performed, Doctor and Location
Pap Smear			
Mammogram			
Bone Density Test			
Colonoscopy			
PSA (Prostate lab test)			

AUTHORIZATION AND RELEASE:
To the best of my knowledge, the questions on this form have been accurately and answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical history. I also authorize the healthcare staff to perform the necessary services I may need.

X_____ _____
Signature of patient or Guardian Date

Benton Family Clinic

Financial Policy

Thank you for choosing Arkansas Health Group as your healthcare provider. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please ask if you have any questions about our Financial Policy, fees, or your responsibility.

Insurance Coverage
Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payment and/or estimated coinsurance and deductibles prior to seeing the provider.

In the event we accept assignment of benefits, the patient is still ultimately responsible for all charges.

Usual and Customary Rates
Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You are responsible for the timely payment of your account.

Motor Vehicle Accidents
In the event you are involved in a motor vehicle accident, you are expected to pay for services rendered. We will gladly provide you with all necessary paperwork to file your insurance claim with your carrier.

Nonpayment
If your account is over 60 days past due, you will receive a letter that you have 20 days to pay your account in full. If the balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this clinic.

Missed Appointments
The clinic will charge $50.00 for no show appointments. This policy will apply once you have missed or canceled with less than 24 hour notice the second appointment with this clinic. More than 3 no shows for appointments may result in termination from our clinic.

Assignment of Insurance Benefits
I request that payment of insurance benefits be made on my behalf to Benton Family Clinic for any services furnished to me by any provider in this clinic. I authorize any holder of medical information about me to release my information needed to determine benefits to my insurance carrier, and where applicable, to the Center of Medicare and Medicaid Services and its agents. I further authorize the clinic or its agents to verify employment date and wage data in the event collection action becomes necessary.

Signature of patient or responsible party Date

Signature of co-responsible party Date

We accept cash, check, Visa, Mastercard or Discover

Benton Family Clinic

Date: _____

Patient Name: _____ **Date of Birth:** _____

PHQ-9				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	**None (0)**	**Several (1)**	**More than half (2)**	**Nearly Every Day (3)**
1. Little interest or pleasure in doing things	0	1	2	3
				3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way. *If 1-3 follow up required (back)	0	1	2	3

Column Totals: _____+ _____+ _____ + _____ = _____

GAD 7				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	**None (0)**	**Several (1)**	**More than half (2)**	**Nearly Every Day (3)**
1.Feeling nervous, anxious or on edge	0	1	2	3
2. Not been able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column Totals: _____ + _____ + _____ + _____ =_____

****If you marked 1 or more on ANY of the problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?**

Not Difficult At All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**