INFECTIOUS DISEASE SPECIALISTS OF NORTHWEST ARKANSAS

Dr. Stephen Hennigan, Dr. Daniel Young, Dr. Andrew Ebers,
Margaret Oliver, APRN and Miranda Bowen-Perkins, APRN

Name: _____DOB: _____Sex: _____Race/Ethnicity: _____

Social Security #: _____ Driver's License #: _____

Address: _____City: _____St: _____Zip: _____

Email: _____Email or Text Reminders? _____

Cell Phone#: _____ Home Phone#: _____

Employed with: _____ Work phone#: _____

Marital Status: _____ Emergency Contact Name: _____Phone#: _____

Spouse or Guarantor Name: _____

Address (if different): _____

DOB: _____Social Security #: _____

Employer: _____ Work Phone#: _____

Primary Insurance (if card not available) _____

Secondary Insurance (if card not available) _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Hennigan, Dr. Young, Dr. Ebers, Margaret Oliver, APRN, and Miranda Bowen- Perkins, APRN all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, including laboratory charges which might be billed by an outside laboratory. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature: _____

Relationship: _____

Date: _____

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

Allergies – Are you allergic to any medications? Yes No

If yes, please list the medications that you are allergic to and the type of reaction

Name	Reaction

Medications – please list current prescriptions and over the counter medications

Name	Dose	Frequency

Antibiotics

Name	Dose	Frequency

Immunizations

- Have you had the pneumonia vaccine within the last 5 years? Yes No
- Have you had the influenza vaccine within the last year? Yes No
- Have you had any COVID vaccination? Yes No (If yes; circle all that apply) Type: Pfizer Moderna J&J

Primary Care Provider: _____

Preferred Pharmacy & Location: _____

Referring Physician: _____

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Have you experienced any of the following symptoms **today**? Please **CHECK** all that apply.

Fever	
Weight loss	
Weight gain	
Night sweats	
Decreased energy	
Visual problems	
Ankle swelling	
Difficulty hearing	
Shortness of breath	
Chest pain	
Problems swallowing	
Cough	
Abdominal pain	
Diarrhea	
Constipation	
Blood in the stool	
Burning with urination	
Difficulty with urination	
Joint pain	
Joint stiffness	
Joint swelling	
Skin rash/lesions	
Headache	
Speech difficulty	
Weakness	
Anxiety	
Depression	
Frequent urination	
Excessive thirst	
Hoarseness	
Easy bruising	
Runny nose	
Hay fever/sneezing	
Current Smoker	
Abnormal vaginal bleeding	

Date: _____

Name: _____

Date of Birth: _____

Travel History

Have you traveled outside of the country in the last 5 years?

Yes No

Have you traveled outside of this area in the last 6 months?

Yes No

Animal Contact – check all that apply

Pets	
Cattle	
Chickens	
Rabbits	
Other Birds	
Dead Animals	
Hunting	
Recent Tick Bite	

Other

- Do you have any history of exposure to Tuberculosis (TB)? Yes No
- Have you ever had a TB skin test? Yes No
- Have you ever had a sexually transmitted disease? Yes No

If yes please circle all that apply:

Gonorrhea Chlamydia Syphilis Herpes HIV Hepatitis

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Name:_____ Date of Birth:_____ Date: _____

Medical History – please select all that apply

Anxiety		**Neuropathy**	
Asthma		**Seizure Disorder**	
Coronary Artery Disease		**Rheumatoid Arthritis**	
Congestive Heart Failure		**Stroke**	
COPD		**Thyroid Disease**	
Diabetes Mellitus	**Type:**	**HIV/AIDS**	
Dialysis		**Arthritis**	
Kidney Disease/Renal Failure	**Stage:**	**Kidney Stones**	
GERD (acid reflux)		**Urinary Tract Infections**	
High Blood Pressure		**Cancer**	**Type:**
Inflammatory Bowel (IBS)		**High Cholesterol**	
Hepatitis	**Type:**	**Parkinson's Disease**	
Autoimmune Disease	**Type:**	**Heart arrhythmia**	**Type:**

Surgical History – please list all surgeries

Surgery	Date (if known)	Surgery	Date (if known)

Social History

Tobacco Use – Smoke Cigarettes? Yes No
Current: packs/day _____ # of years _____ *Past:* Quit date _____ Packs/Day _____ # of years _____
Other tobacco (circle all that apply): Cigars Pipe Chewing Tobacco Vape *Current User* *Past User*
Alcohol Use – Do you drink alcohol? Yes No If yes; please circle: Beer Wine Liquor # of drinks/week _____

Other:
Do you use marijuana? Yes No Do you use other recreational drugs? Yes No
Have you ever used needles to inject drugs? Yes No

Family History – please **check** all that apply

	Diabetes	High Blood Pressure	Cancer (please specify)	Heart Disease	High Cholesterol	Kidney Disease	Stroke	Other (please specify)
Father								
Mother								
Siblings								

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We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

We reserve the right to charge patients a fee and/ or terminate our relationship with a patient who fails to keep their appointments without notifying our office in advance. Patients who no show three consecutive times may be dismissed for the practice thus they will be denied any future appointments.

IDS of Northwest Arkansas believes that good physicians/ patient relationship is based upon understanding and communication. Question about cancellation and no-show fees should be directed to the Business office.

Please sign that you have read, understand and agree to this No Show/ Cancellation Policy.

_____ _____

Patient/ Patient Representative Signature Date

_____ _____

Patient Name- (PLEASE PRINT) Patient – Date of Birth

Thank you,
Dr. Stephen Hennigan, Dr. Daniel Young, Dr. Andrew Ebers,
Maggie Oliver, APRN, Miranda Bowen- Perkins, APRN and staff.

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Confidentiality Statement

I, _____, ID Specialists of Northwest Arkansas or their staff authorization to release information to the following person or persons(**this includes any family members or friends**):
_____, _____, _____,
_____, _____ about my medical treatment or test results.

I understand that if I do not complete the above and have it witnessed by an office staff member that the information will only be released to me and only with verification.

_____ _____

Patient Signature **Date**

_____ _____

Witness (OFFICE STAFF ONLY) **Date**

Acknowledgement

I have read the Privacy Notice or have had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I do not understand.

_____ _____

Patient Signature **Date**

For Staff use Only:

_____
_____
_____