

**PATIENT INFORMATION – Please Print**

Patient Name \_\_\_\_\_  
Last First Middle

Sex:  M  F Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_ E-mail \_\_\_\_\_

Please check one:  Married  Single  Partner  Divorced  Widowed  Separated

Race:  White  African American  Asian  Native Hawaiian/Other Pacific Islander  
 Native American Indian/ Alaskan  Other Race \_\_\_\_\_

Ethnicity (Origin):  Not Hispanic or Latino  Hispanic or Latino Preferred (Primary) Language: \_\_\_\_\_

Have you been seen at this clinic before?  Yes  No If so, when? \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Primary Physician \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Street \_\_\_\_\_

**EMAIL AUTHORIZATION**

Email Address \_\_\_\_\_

By providing my email address above, I hereby agree to allow MANA to contact me by email with e-newsletters, wellness reminders, health news and updates regarding health-related services provided by MANA. I understand that MANA will not share the information provided above with outside marketing companies.

**EMPLOYER INFORMATION**

Is today's visit work related?  Yes  No

Name of Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**REFERRAL**

If you are a new patient, how did you hear about the clinic or physician?

- |  |  |
|--|--|
| 01 <input type="checkbox"/> Recommended by a friend or family member | 08 <input type="checkbox"/> Newspaper or Magazine                |
| 02 <input type="checkbox"/> Washington Regional Medical Center       | 09 <input type="checkbox"/> Employer                             |
| 03 <input type="checkbox"/> Phone Directory / Yellow Pages           | 10 <input type="checkbox"/> Internet or clinic web site          |
| 04 <input type="checkbox"/> Referred by a Physician _____            | 11 <input type="checkbox"/> Drove by clinic / Location of clinic |
| 05 <input type="checkbox"/> Insurance Plan Directory                 | 12 <input type="checkbox"/> Other Source: Please list _____      |
| 06 <input type="checkbox"/> Newcomers Group or Chamber of Commerce   | 13 <input type="checkbox"/> Treated by physician in the hospital |
| 07 <input type="checkbox"/> Community or Company Health Fair         | 14 <input type="checkbox"/> Return Patient/ Not applicable       |

➔➔ Please complete the BACK of the form ➔➔

**PERSON RESPONSIBLE FOR PAYMENT**

My self/ My spouse (skip to the next section) OR: (List Father, Mother, Guardian or other)

Responsible Party \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

1. If you are covered by one of the following insurance plans, please mark the appropriate plan:

- Aetna       AMCO (or AMCO affiliate)       Cigna       Blue Cross Blue Shield
- Novasys Choice Network / AR HealthNet       Tyson       United Healthcare       Qual-Choice

2. If you have one of the insurance plans listed above, please complete the following for the person that carries the insurance.

ID# \_\_\_\_\_ GP# \_\_\_\_\_ Phone# \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Policy Holder's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Child  Step-Child  Other

**INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT**

I hereby authorize Medical Associates of Northwest Arkansas (MANA) to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received a copy of the Patient Notice of Privacy Practices from Medical Associates of Northwest Arkansas.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

\_\_\_\_\_

If you would like to authorize MANA clinic to release information to a **family member, spouse, or personal representative**, please complete an **Individual Authorization Form** provided by the receptionist.