



MEDISERVE
WALK-IN CLINIC

A MANA Clinic

PATIENT REGISTRATION

www.mana.md

Internal Use Only



mana

medical associates

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 _____

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

Reason for today's visit _____

Primary Physician _____

Preferred Pharmacy _____ Street _____

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 |

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 _____

➔➔ Please complete the BACK of the form ➔➔

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.