



PATIENT REGISTRATION

www.mana.md

Internal Use Only

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
Employer Work Phone
Please check one: Married Single Partner Divorced Widowed Separated
Primary Physician
Preferred Pharmacy Street

SPOUSE or PARENT (if minor) INFORMATION

Name Date of Birth Social Security
Employer Address Phone

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact Relationship
Phone Address City State Zip

REFERRAL

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

- 01 Recommended by a friend or family member
02 Washington Regional Medical Center
03 Phone Directory / Yellow Pages
04 Referred by a Physician
05 Insurance Plan Directory
06 Newcomers Group or Chamber of Commerce
07 Community or Company Health Fair
08 Newspaper or Magazine
09 Employer
10 Internet or clinic web site
11 Drove by clinic / Location of clinic
12 Other Source: Please list
13 Treated by physician in the hospital
14 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

Please provide a copy of your insurance card to the receptionist.

MEDICARE Medicare No. _____ - _____ - _____ - _____ Effective Date _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Medical Associates of Northwest Arkansas for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

PRIMARY INSURANCE _____

ID# _____ GP# _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ DOB _____ SS# _____

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

SECONDARY INSURANCE _____

ID# _____ GP# _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ DOB _____ SS# _____

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.