

PATIENT INFORMATION – Please Print

Patient Name _____
Last
First
Middle

Sex: M F Date of Birth _____ Social Security # _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

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: _____

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.

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 <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

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 to me by the 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.