



**PATIENT REGISTRATION**

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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**

Emergency Contact \_\_\_\_\_ *Relative or Friend not in the home* 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       |

**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.