

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.

Patient Name _____

Date of Visit _____ Date of Birth _____

Health History 1 | Health History 2 | Review of Systems

<input type="checkbox"/> All Negative	Which Side ?	
	Please circle one	if yes, when?
An injury to either of your legs that required an operation or casting?	R L B Neither	
A deep vein thrombosis (D.V.T.) AKA a blood clot in your leg?	R L B Neither	
Phlebitis:	R L B Neither	
A Venous Stasis Ulcer?	R L B Neither	
Hemorrhage from a Varicose Vein?	R L B Neither	
Sclerotherapy:	R L B Neither	
Vein Stripping:	R L B Neither	

Criteria For Medical Necessity

Patient's Complaint: _____

Patient Works as ... _____ Retired?

Patient has had to:

<input type="checkbox"/> wear support hose	<input type="checkbox"/> exercise	# of Childbirths: <input type="text"/>
<input type="checkbox"/> limit activities	<input type="checkbox"/> lose weight: <input type="text"/> lbs	
<input type="checkbox"/> take time off work	<input type="checkbox"/> elevate legs	Cons Treat Duration: <input type="text"/>
<input type="checkbox"/> take pain medicine	<input type="checkbox"/> take oral analgesics	<input type="text"/>

Please indicate if you have any of the following conditions

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hypertension	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Fainting	<input type="checkbox"/> Cancer	<input type="checkbox"/> Tobacco Use

Current Medication (Checklist)

<input type="checkbox"/> Coumadin	<input type="checkbox"/> Topical Skin Medications
<input type="checkbox"/> Plavix	<input type="checkbox"/> Antibiotics
<input type="checkbox"/> Daily Aspirin	<input type="checkbox"/> Steroids

For Women Only

<input type="checkbox"/> Pregnant or think you might be?	<input type="checkbox"/> Taking Oral Contraceptives?
<input type="checkbox"/> Currently Nursing (Breast Feeding)?	<input type="checkbox"/> On Hormone Replacement Therapy (HRT)?
<input type="checkbox"/> Do you think you will have more children?	<input type="checkbox"/> Do you anticipate starting HRT Soon?

Patient Name _____

Date of Visit _____ DOB _____

Health History 1 | Health History 2 | Review of Systems

Please list all medications that you take at least three times per week:

Allergies

Please list any and all allergies (click text box to edit list):

Patient has allergies important to us.

Family History: Please indicate if any of the following conditions were present in your immediate family members

- | | |
|---|--|
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Venous Ulcers | <input type="checkbox"/> A history of Vein Surgery |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Blood Clots |

Past Surgical History

Have you ever had surgery? If you have had surgery, what type and when?

Additional Medical History Not Mentioned Above:

Are you presently seeing another physician for anything NOT mentioned above?

If so, What is the Doctors Name?:

Currently Seeing Another MD For What Text:

Have you ever been hospitalized for anything NOT mentioned above?

If so, for what, at what Hospital, and when?

Patient Name _____

Date of Visit _____ DOB _____

Health History 1 | Health History 2 | Review of Systems

Do you currently have any of the following? If yes, please explain.

All Negative (Page 3)

General Health/Recent illness

Fever Chills Weight loss Loss of appetite

Eyes

Visual acuity Double vision Excessive tearing Crusting

ENT (Ear, Nose, and Throat)

Recent change in hearing Discharge Sore throat Dizziness Ringing in the ears

Cardiac (History of heart disease)

Chest pain Shortness of breath Waking from sleep breathless Cardiac medicine

Respiratory

Shortness of breath Productive cough Coughing up blood Painful breathing

Gastrointestinal

Change in bowel movements Black stool Red or bloody stool Vomiting Abdominal

Genitourinary

Incontinence Frequent urination Urgent urination waking at night to urinate

Musculoskeletal

Change in walking ability or strength Painful joints

Skin

Problematic rashes or itching Changes in skin color Sores that will not heal

Neurological

Unexpected/unexplained numbness Tingling Loss of memory Loss of movement

Psychiatric

Suicidal thoughts or hallucinations