Patient Information Form

☐ New Patient
☐ Established Patient

ACCOUNT NUMBER

Is this work or accident related? ☐ **NO** ☐ **YES** **Date of Injury** ______________

PATIENT INFORMATION			
PATIENT NAME (LAST)	FIRST		HOME PHONE
ADDRESS			CELL PHONE
CITY, STATE	ZIP	D.O.B.	SOCIAL SECURITY
EMAIL ADDRESS		GENDER	MARITAL STATUS
EMPLOYER	EMPLOYER ADDRESS		
EMPLOYER PHONE	EXT	REFERRING PHYSICAN	
SPOUSE NAME		PHONE NUMBER	
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT		PHONE NUMBER

GUARANTOR/RESPONSIBLE BILLING PARTY INFORMATION			
GUARANTOR	SOCIAL SECURITY	PHONE NUMBER	
BILLING ADDRESS			
CITY, STATE	ZIP	EMPLOYER	
EMPLOYER ADDRESS			EMPLOYER PHONE

INSURANCE INFORMATION (Please present your insurance cards/forms to receptionist)			
PRIMARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		
SECONDARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		
TERTIARY INSURANCE	POLICY HOLDER	D.O.B.	SSN
ADDRESS			PHONE
POLICY NUMBER	GROUP NUMBER		

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. YOUR FINANCIAL RESPONSIBILITY IS TO ENSURE ARKANSAS FAMILY CARE NETWORK IS PAID FOR SERVICES RENDERED. THIS INCLUDES LIABILITY COVERED INJURIES, AS BILLS WILL NOT BE POSTPONED IN ANTICIPATION OF LEGAL SETTLEMENT. INFORMATION WILL BE PROVIDED TO YOU TO FILE YOUR OWN INSURANCE AND SUPPLIED TO YOUR ATTORNEY UPON REQUEST.

I HEREBY AUTHORIZE ARKANSAS FAMILY CARE NETWORK DOCTORS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS OR I REMAIN A PATIENT.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Updated 8/17/2022