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	RACE	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.

______________________________________ ______________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Updated 8/17/2022

New Patient Medical History Form

(This information is confidential and will not be released without your consent.)

Name: ____
First *Middle* *Last*

Today's Date: ________/________/________
Month *Day* *Year*

Date of Birth: ________/________/________
Month *Day* *Year*

Email Address: ______________________________ Preferred Pharmacy: __________________________

Reason for today's visit:

____

____

How did you hear about us?

____

____

Current medications: (include prescriptions, over the counter, and herbal)

Name of Medication:	Dose:	Frequency:

Are you allergic to any medications? ☐ **Yes** ☐ **No**

Name of Medication:	Type of Reaction:

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions? Please give the year.

☐	Anemia		☐	Hepatitis	
☐	Anxiety/Depression		☐	High Blood Pressure	
☐	Arthritis		☐	Kidney Disease	
☐	Asthma		☐	Migraines	
☐	Cancer		☐	Seasonal Allergies	
☐	High Cholesterol		☐	Sleep Apnea	
☐	Congestive Heart Failure		☐	Thyroid Disease	
☐	COPD/Emphysema		☐	*Other (please specify)*	
☐	Diabetes		☐	*Other (please specify)*	
☐	Gout		☐	*Other (please specify)*	
☐	Heart Attack		☐	*Other (please specify)*	

PAST SURGICAL HISTORY

Type of Procedure:	Approximate Date/Year:	Name of Surgeon:

FAMILY MEDICAL HISTORY

Family Member	Living	Deceased	Age	Cause of Death
Father				
Mother				
Sibling				
Sibling				
Sibling				

Have any of your blood relatives ever been diagnosed with any of the following conditions? If so, who?

☐	Condition	Who	☐	Condition	Who
☐	Anemia		☐	Hepatitis	
☐	Anxiety/Depression		☐	High Blood Pressure	
☐	Arthritis		☐	Kidney Disease	
☐	Asthma		☐	Migraines	
☐	Cancer		☐	Seasonal Allergies	
☐	High Cholesterol		☐	Sleep Apnea	
☐	Congestive Heart Failure		☐	Thyroid Disease	
☐	COPD/Emphysema		☐	*Other (please specify)*	
☐	Diabetes		☐	*Other (please specify)*	
☐	Gout		☐	*Other (please specify)*	
☐	Heart Attack		☐	*Other (please specify)*	

HABITS

Tobacco: ☐ YES ☐ NO If yes, type: ___________________ How much?_______________

Past Tobacco Use: ☐ YES ☐ NO If yes, type: ___________________ How much?_______________

Alcohol: ☐ YES ☐ NO If yes: ☐RARELY ☐DAILY ☐OCCASIONALLY

Past Alcohol Use: ☐ YES ☐ NO If yes: ☐RARELY ☐DAILY ☐OCCASIONALLY

Illegal Drugs: ☐ YES ☐ NO If yes, type: ___________________ How much?_______________

Past Illegal Drugs: ☐ YES ☐ NO If yes, type: ___________________ How much?_______________

STRESS

Present level of stress: ☐ MINIMAL ☐ MODERATE ☐ LARGE

Do you find it difficult to relax? ☐ YES ☐ NO

Do you find it difficult to sleep? ☐ YES ☐ NO

Do you usually attempt to do two or more things at one time? ☐ YES ☐ NO

Have you had several changes in your life in the past year? ☐ YES ☐ NO

NUTRITION

Number of meals per day? _______________________ Recent weight loss or gain? ______________________

Do you follow a special diet? _____________________ If so, what kind of diet? _________________________

Are you up-to-date on these screening tests/exams? Please give month/year of last one:

Exam	Year	Exam	Year
Bone Density Testing	___________________	Physical Exam with Labs	___________________
Colonoscopy	___________________	Prostate Exam	___________________
EKG	___________________	Pap Smear	___________________
Mammogram	___________________	Tetanus Shot	___________________

Clinic Policies and Procedures

Thank you for choosing Barg Family Clinic for your primary care needs. Below you will find a detailed description of our policies and procedures regarding office visits and other clinical services, late/missed appointments, and filling out paperwork such as FMLA forms.

Office Visits and Other Clinical Services

Insured patients will be expected to pay your coinsurance, any deductible not met, and/or copay every time you see your provider. You will be responsible for all non-covered charges (labs, procedures, etc.) not payable by your insurance company.

Self-pay patients will be expected to pay in full at the time of service. Self-pay patients who schedule an appointment at least 72 hours in advance will receive a good faith estimate (GFE) notification that outlines the expected charge(s) for the scheduled service.

Late Arrivals and Missed Appointments

If you have a phone that receives text messages and you are signed up to receive texts from us, we will send you a text reminder 1-2 days prior to your appointment time. However, we expect our patients to take responsibility for their appointments. If you are more than 15 minutes late for your appointment, your time slot is no longer guaranteed. We will make every effort to reschedule your appointment for another available slot later the same day. If you miss an appointment or did not call to cancel your appointment at least 24 hours in advance of your scheduled appointment time, you will be charged a “no-show” fee of $50. This applies to appointments scheduled and cancelled on the same day.

Forms and Letters

Please provide the front desk with any forms or letters requiring provider documentation after completing **your** portion of the form. We are unable to accept any forms left at the office without a name and date of birth. Please note that some forms may require you to be seen by a provider before completion. In this case you will be asked to schedule an appointment and will only be charged your co-pay. For forms that do not require an office visit, there will be a $25 fee that must be paid prior to form completion. Please allow five (5) business days for the office to complete your forms request.

Patient Name Patient Signature Date

Updated 8/17/2022

A member of the Arkansas Family Care Network, P.A.

ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Arkansas Family Care Network's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic location where I receive health care services.

Signature ____ Date ______________________________

Print Name____ Date of Birth _______________________

If you are not the patient, please fill out the following information.

Name ____

Relationship to Patient ____

Address ____

____

Telephone ____

Please furnish a copy of any conservator/guardianship papers with this form.

If you would like someone else to have access to your protected health information, please fill out the following information.

I, ____, HEREBY CONSENT TO ALLOW THE FOLLOWING PERSON(S) ACCESS TO INFORMATION ON MY ACCOUNT THAT WOULD OTHERWISE BE CONSIDERED PROTECTED HEALTH INFORMATION.

1. ____ 3. ____

2. ____ 4. ____

Updated 8/17/2022