

**Patient Information Form**

<input type="checkbox"/> <b>New Patient</b>
<input type="checkbox"/> <b>Established Patient</b>

Is this work or accident related?    **NO**    **YES**   Date of Injury \_\_\_\_\_

<b>ACCOUNT NUMBER</b>

<b>PATIENT INFORMATION</b>			
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 PHYSICIAN	
SPOUSE NAME		PHONE NUMBER	
EMERGENCY CONTACT	RELATIONSHIP TO PATIENT		PHONE NUMBER

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

<b>INSURANCE INFORMATION (Please present your insurance cards/forms to receptionist)</b>			
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



**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.

<input type="checkbox"/> Anemia		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Anxiety/Depression		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Migraines	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Seasonal Allergies	
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Sleep Apnea	
<input type="checkbox"/> Congestive Heart Failure		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> COPD/Emphysema		<input type="checkbox"/> <i>Other (please specify)</i>	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> <i>Other (please specify)</i>	
<input type="checkbox"/> Gout		<input type="checkbox"/> <i>Other (please specify)</i>	
<input type="checkbox"/> Heart Attack		<input type="checkbox"/> <i>Other (please specify)</i>	

**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?

<input type="checkbox"/>	Anemia		<input type="checkbox"/>	Hepatitis	
<input type="checkbox"/>	Anxiety/Depression		<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	Arthritis		<input type="checkbox"/>	Kidney Disease	
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	Migraines	
<input type="checkbox"/>	Cancer		<input type="checkbox"/>	Seasonal Allergies	
<input type="checkbox"/>	High Cholesterol		<input type="checkbox"/>	Sleep Apnea	
<input type="checkbox"/>	Congestive Heart Failure		<input type="checkbox"/>	Thyroid Disease	
<input type="checkbox"/>	COPD/Emphysema		<input type="checkbox"/>	<i>Other (please specify)</i>	
<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	<i>Other (please specify)</i>	
<input type="checkbox"/>	Gout		<input type="checkbox"/>	<i>Other (please specify)</i>	
<input type="checkbox"/>	Heart Attack		<input type="checkbox"/>	<i>Other (please specify)</i>	

**HABITS**

Tobacco:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes, type: _____	How much? _____
Past Tobacco Use:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes, type: _____	How much? _____
Alcohol:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes: <input type="checkbox"/> RARELY <input type="checkbox"/> DAILY <input type="checkbox"/> OCCASIONALLY	
Past Alcohol Use:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes: <input type="checkbox"/> RARELY <input type="checkbox"/> DAILY <input type="checkbox"/> OCCASIONALLY	
Illegal Drugs:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes, type: _____	How much? _____
Past Illegal Drugs:	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If yes, type: _____	How much? _____

**STRESS**

Present level of stress:	<input type="checkbox"/>	MINIMAL	<input type="checkbox"/>	MODERATE	<input type="checkbox"/>	LARGE
Do you find it difficult to relax?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Do you find it difficult to sleep?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Do you usually attempt to do two or more things at one time?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Have you had several changes in your life in the past year?	<input type="checkbox"/>	YES	<input type="checkbox"/>	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.

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Patient Name

Patient Signature

Date



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. \_\_\_\_\_