Arkansas Internal Medicine Clinic, P.A.
1401 Kanis Park Drive * Suite 200* Little Rock AR * 72205

PATIENT INFORMATION FORM

Today's Date: _____ **Referring Physician:** _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

Last Name _____ **First Name** _____ **Middle Name** _____

Address: _____

City/ State/ Zip: _____

Please check one: Employed ____ Not Employed____ Retired____ Disabled____ F/T Student ____ P/T Student____

Employer Name & Address_____

Soc. Sec. #:_____ **Driver License**_____ **Age:** _____

Home phone: _____ **Work Phone**: _____ **Ext**: _____ **Cell Phone**: _____

Date of Birth: _____ **Email Address**: _____ **Gender:** Male _____ Female_____

How would you like to be contacted? Please check one: Home phone___ Cell Phone ____ Work phone____ Email ____ Letter ____

Please check one : **Race**: Black____ White____ Asian ____ Other____ Declined ____ **Ethnicity**: Hispanic___ Non- Hispanic___

Please check one: Single____ Married____ Divorced_____ Widowed____ Legally Separated____ **Preferred Language**: _____

PATIENT/DEPENDENT INFORMATION

Name: _____

Address: _____

City/ State/ Zip: _____

Please check one: Employed ____ Not Employed____ Retired____ Disabled____ F/T Student ____ P/T Student____

Employer Name & Address_____

_____

Home phone: _____ **Work Phone**: _____ **Ext**: _____ **Cell Phone**: _____

Birthday: _____ **Soc. Sec. #**:_____ **Marital Status**: Single____ Married____ Other_____

Is this a work related / auto accident injury? _____ **If so, date of injury**_____

Who may we notify in case of an injury?

Name: _____ **Relationship**: _____

Day phone: _____ **Night Phone**: _____ **Other Phone**: _____

Name: _____ **Relationship**: _____

Day phone: _____ **Night Phone**: _____ **Other Phone**: _____

INS TAB

.

INSURANCE INFORMATION

Primary Insurance: _____

Address: _____

City / State / Zip: _____ **Phone: #**: _____

Insured's Name: _____ **DOB**: _____

ID#: _____ **Group Name & #**: _____

Insured's Relationship to patient: _____ **Is this an insurance plan through your employer**? _____

Secondary Insurance: _____

Address: _____

City / State / Zip: _____ **Phone**: #: _____

Insured's Name: _____ **DOB**: _____

ID#: _____ **Group Name & #**: _____

Insured's Relationship to patient: _____ **Is this an insurance plan through your employer?** _____

How did you learn of our practice? _____**Referred by**: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to
Name of Insurance Company
Dr. _____ all medical benefits, if nay otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Insured / Guardian Date

I hereby give my consent to Arkansas Internal Medicine, P.A. to release medical information pertaining to my claim to my insurance company and /or companies or my attorney.

Patient Signature: _____ **Date:** _____

INS TAB