LITTLE ROCK FAMILY PRACTICE CLINIC

Is This Work Related?
Yes _____ No _____
Date of Injury _____

PATIENT INFORMATION
Print Clearly

Acct. _____
Dr. _____

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

PATIENT DATA

Patient Name _____ Age _____ Date of Birth _____
Male ( ) Female ( ) Married ( ) Single ( ) Divorced ( ) Widowed ( )
Address _____
City _____ State _____ Zip _____
Home Phone _____ Social Security Number _____
Employer's Name _____
Address _____ Telephone # _____

Responsible Party _____ Responsible Party SS# _____
Responsible Party Employed By _____ Phone _____
Spouse of Responsible Party _____
Name _____ Employed By _____ Phone _____

INSURANCE INFORMATION: WE WILL NEED A COPY OF YOUR INSURANCE CARD

Primary Insurance _____ Effective Date _____ Co-Pay _____
Address _____ City _____ State _____ Zip _____
Phone Number ( ) _____ Policy # _____ Group # _____
Subscriber Name _____ Relationship to patient (circle) Mother Father Other _____
Subscriber's Employer _____ City _____ State _____ Zip _____
Employer Phone _____ Subscribers DOB _____ SSN _____

Secondary Insurance _____ Effective Date _____ Co-Pay _____
Address _____ City _____ State _____ Zip _____
Phone Number ( ) _____ Policy # _____ Group # _____
Subscriber Name _____ Relationship to patient (circle) Mother Father Other _____
Subscriber's Employer _____ City _____ State _____ Zip _____
Employer Phone _____ Subscribers DOB _____ SSN _____

Tertiary Insurance _____ Effective Date _____ Co-Pay _____
Address _____ City _____ State _____ Zip _____
Phone Number ( ) _____ Policy # _____ Group # _____
Subscriber Name _____ Relationship to patient (circle) Mother Father Other _____
Subscriber's Employer _____ City _____ State _____ Zip _____
Employer Phone _____ Subscribers DOB _____ SSN _____

EMERGENCY Please give name and telephone number of a friend or relative that does not live at your address.

NAME _____ PHONE _____

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 LRFPC-W 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 THE DOCTORS OF LITTLE ROCK FAMILY PRACTICE CLINIC - WEST 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 OF 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 GUARDIAN X _____

DATE _____

LITTLE ROCK FAMILY PRACTICE CLINIC

NEW PATIENT INFORMATION

How did you hear about Little Rock Family Practice Clinic?

New Patient Medical History

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

Name Today's Date

Address Home Phone ( )

Apt. # Cell Phone ( )

Work Phone ( )

E-Mail Address

Date of Birth Height Weight

Emergency Contact Name Phone ( )

Reason for Today's Visit:

Current Medications (Includes Prescriptions, Over the Counter, and Herbal):

	Name of Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Are you allergic to any medications? Yes ☐ No ☐

	Name of Medications	Type of Reaction
1.		
2.		
3.		

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

Anemia		Hepatitis	
Anxiety/Depression		High Blood Pressure	
Arthritis		HIV/AIDS	
Asthma		Kidney Disease	
Cancer		Migraines	
High Cholesterol		Seasonal Allergies	
Congestive Heart Failure		Sleep Apnea	
COPD/Emphysema		Thyroid Disease	
Diabetes		Other	
Gout		Other	
Heart Attack		Other	

Past Surgical History:

	Type of Procedure	Name of Surgeon	Approximate Date/Year
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Tell us about yourself:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Occupation:

Children: Number Ages

Habits:

Do you smoke? ☐ Yes ☐ No How much?

Have you ever smoked? ☐ Yes ☐ No When did you quit?

Oral tobacco? ☐ Yes ☐ No How much?

Any past use of oral tobacco? ☐ Yes ☐ No When did you quit?

Do you drink alcohol? ☐ Yes ☐ No How often?

Family Medical History:

	Living	Deceased	Age	Cause of Death
Father	☐	☐		
Mother	☐	☐		
Sister(s)	☐	☐		
Brother(s)	☐	☐		

Have any of your blood relatives ever had any of the following conditions? If so, who?

Anemia		High Blood Pressure	
Anxiety/Depression		Kidney Disease	
Other Mental Illness		Migraines	
Arthritis		Stroke	
Asthma		Thyroid Disease	
Cancer		Seasonal Allergies	
High Cholesterol		Sleep Apnea	
Congestive Heart Failure		Other	
COPD/Emphysema		Other	
Diabetes		Other	
Gout		Other	
Heart Attack		Other	

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	