

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	