

Arkansas Pediatric Clinic

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PATIENT INFORMATION FORM

Patient's full name: _____ Date of Birth: _____
(Male) __ (Female) __ Soc. Security # _____ Home Phone () _____

Address _____
Street City State Zip Code County

Please list the names of other children and date of birth:

Referring physician: _____ UPIN# _____

Address: _____ Phone: _____
Fax: _____

Responsible party: _____

Father's name: _____ Mother's name: _____

Soc. Security No: _____ Soc. Security No: _____

Date of Birth: _____ Date of Birth: _____

Employer: _____ Employer: _____

Work Phone No: _____ Work Phone No: _____

Marital Status: (Married) __ (Divorced) __ (Single) __ Mother's Maiden Name _____

Home telephone if different from above: _____

Relative or friend to notify in case of emergency: (not living at same address as patient)

Name: _____ Telephone No: _____

Address: _____

Day Care Information: _____ Telephone No: _____

INSURANCE INFORMATION

Name of primary insurance: _____

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts, included but not limited to co-payments and deductibles due under my insurance plan, incurred by myself for services received from the Arkansas Pediatric Clinic whether covered by insurance or not.

Signature _____ Date _____

I give my permission for Arkansas Pediatric to treat my child. _____
Signature Date

I give my permission for a Nurse Practitioner to treat my child on occasion. _____
Signature Date