Arkansas Psychiatric Clinic (APC)

New Patient Information

Full Name: **Social Security Number:**

Date of Birth: **Age:** Sex: Marital Status:

Address: City: State: Zip:

Language: Race/ Ethnicity: Non-Hispanic Hispanic Unknown

Phone: Cell: Email:

Pharmacy: **Previous Physician:** Religion:

Referring Physician (if applicable): **Primary Doctor (if applicable):**

Employer: Work Phone:

Referring Physician Address:_____

Referring Physician FAX:_____**PHONE**_____

Primary Doctor Address:_____

Primary Doctor FAX:_____**PHONE**_____

Guarantor Information (Person/Entity financially responsible for the patient)

Name: Relationship:

Social Security Number: **Date of Birth:** Phone:

Address: City: State: Zip:

Employer: Work Phone:

Spouse Information

Name: Relationship:

Social Security Number: **Date of Birth:** Phone:

Address: City: State: Zip:

Employer: Work Phone:

Emergency Contact

Name: Relationship:

Address: City: State: Zip:

Phone: Cell: **Approved HIPAA contact:** **Yes** **No**

Insurance Information

WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) AND DRIVERS LICENSE FOR OUR FILES

Primary Insurance:	**Secondary Insurance:**
Mail Claims To:	Mail Claims To:
Group No.: **ID No.:**	**Group No.:** **ID No.:**
Subscriber's Name:	Subscriber's Name:
Relationship to pt:	Relationship to pt:
Address:	Address:
City, State, Zip:	City, State, Zip:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's Soc. Sec.#:	**Subscriber's Soc. Sec.#:**
Subscriber's Employer:	**Subscriber's Employer:**

Authorization, Consent and Acknowledgment

I hereby authorize my insurance benefits to be paid directly to APC. I consent to the use or disclosure of my protected health information by APC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of APC. I have the right to revoke this consent in writing at any time, except to the extent that APC has taken action in reliance on this consent. The Notice of Privacy Practices for APC has been provided to me.

_____ _____

Signature of Patient or Guardian **Date**