**Arkansas Psychiatric Clinic (APC) – New Patient Information**

|  |
| --- |
| **Patient Name**: **Date of Birth: Social Security No:**  |
| **Sex: Marital Status: Language: Ethnicity:** Non-Hispanic Hispanic Unknown |
| **Address: City: State: Zip:** |
| **Phone: Cell: Email: Religion:** |
| **Referring Physician: Primary Doctor (if different):**  |
| **How did you hear about us?**  |
| **Employer: Work Phone:**  |
| **Guarantor Information (Person/Entity financially responsible for the patient)** |
| **Name: Relationship:** |
| **Date of Birth: Social Security No: Phone:**  |
| **Address: City: State: Zip:**  |
| **Employer: Work Phone:**  |
| **Spouse Information** |
| **Name: Date of Birth: Social Sec No: Ph:**  |
|  |
| **Address: City: State: Zip:**  |
| **Employer: Work Phone:**  |
| **Emergency Contact** |
| **Name: Relationship: Phone:**  |
| **Address: City: State: Zip:** |
| **Insurance Information –** *WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) AND PHOTO ID* |
| **Primary Ins:** | **Secondary Ins:** |
| **ID: Group No:** | **ID: Group No:** |
| **Claims Address:** | **Claims Address:** |
| **City: State: Zip:** | **City: State: Zip:** |
| **Subscriber Name:** | **Subscriber Name:** |
| **Relationship to pt:** | **Relationship to pt:** |
| **Subscriber Soc Sec No:** | **Subscriber Soc Sec No:** |
| **Subscriber Date of Birth:** | **Subscriber Date of Birth:** |
| **Subscriber Employer:** | **Subscriber Employer:** |

**Authorization, Consent, and Acknowledgement**

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 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 of this consent. The Notice of Privacy Practices for APC has been provided to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of Patient or Guardian Date**