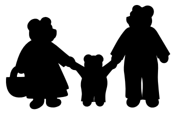

Northwest Arkansas Pediatric Clinic, P.A.

A MANA Clinic

Patient Registration Form

3380 N. Futrall
Fayetteville, AR 72703
www.nwapeds.com
Urgent Care 479-442-7322
Well Care 479-443-3471

Internal Use Only
EMR Account # ____________________

mana
medical associates

*Please complete **front** and **back** of form.*

Patient Name ______________________ DOB ____________ Sex ________ Today's Date __________

Allergies ______________________________ SS # ______________

Sibling ______________ DOB ____________ Sibling ______________ DOB ____________

Sibling ______________ DOB ____________ Sibling ______________ DOB ____________

RESPONSIBLE PARTY INFORMATION

GUARDIAN(S) / FOSTER PARENT(S): Please complete the parent information and indicate that the child is in your custody.

Responsible Party ______________________________ Home Phone ______________

Address ______________________ City ______________ State ______ Zip ________

Parent E-Mail Address ______________ @ ______________ Cell Phone ______________

This address will be used to send news about NWA Pediatric Clinic and Pediatric Health. We will not share or sell this address with any other business.

Father's Name ______________________ DOB ____________ SS # ______________

Employer ______________________________ Work Phone # ______________

Mother's Name ______________________ DOB ____________ SS # ______________

Employer ______________________________ Work Phone # ______________

Mother's Maiden Name ______________________________

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

INSURANCE COMPANY INFORMATION

Primary
Company ______________ ID # ____________ GP# ____________ Phone # ____________

Address ______________________ City ______________ State ______ Zip ________

Policyholder's Name ______________________________

Secondary
Company ______________ ID # ____________ GP # ____________ Phone # ____________

Address ______________________ City ______________ State ______ Zip ________

Policyholder's Name ______________________________

EMERGENCY INFORMATION

- Relative or Friend not in home -

Name ______________________ Address ______________ Phone ______________

Address ______________________ City ______________ State ______ Zip ________

Employer ______________________________ Employer's Phone # ______________

Relationship to Patient ______________________________

-- Continued --

REFERRAL

How were you referred to the clinic? Please circle the appropriate source listed below.

Source	Code
Recommended by a friend or family member	01
Washington Regional Medical Center	02
Phone Directory / Yellow Pages	03
Referred by a Physician (Please List Below):	04
______________________________	
Insurance Plan	05
Newcomers Group or Chamber of Commerce	06
Health Fair	07
Newspaper or Magazine	08
Employer	09
Internet / Clinic Web Site	10
Location or Signage	11
Other Source (please List Below):	12
______________________________	
Treated by Physician in the Hospital	13
Return Patient	14

ACKNOWLEDGE OF PAYMENT

All professional services rendered are charged to the patient. The necessary forms will be provided to insure your prompt reimbursement by your insurance carrier. The guardian is responsible for all fees, deductibles, and co-payments required by your insurance carrier. Payment is due in full the day services are rendered. Unless we have a participating agreement with your insurance carrier.

Signed ______________________________ Date ______________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION & INSURANCE ASSIGNMENT

I hereby authorize the Northwest Arkansas Pediatric Clinic to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by insurance.

Signed ______________________________ Date ______________