Baptist Health Family Clinic – Otter Creek

New Patient Information

Full Name:			Social Security Number:	
Date of Birth:	Age:	Sex:	Marital Status:	
Address:	City:	State:	Zip:	
Race:	Language:	Ethnicity:	Marital Status:	Smoker: Y N
Phone:	Cell:	Email:		
Drivers License Number:	Pharmacy:	Previous Physician:		
Referring Physician (if applicable):		PCP (if applicable):		
Employer:		Work Phone:		

Spouse/Parent Information

Name:			Relationship:
Social Security Number:		Date of Birth:	Phone:
Address:	City:	State:	Zip:
Employer:		Work Phone:	

Additional Guardian/Guarantor Information

Name:			Relationship:
Social Security Number:		Date of Birth:	Phone:
Address:	City:	State:	Zip:
Employer:		Work Phone:	

Emergency Contact

Name:	Relationship:
Phone:	Cell:

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.:
Policy Holder's Name:	Policy Holder's Name:
Relationship to pt:	Relationship to pt:
Address:	Address:
City, State, Zip:	City, State, Zip:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Soc. Sec.#:	Policy Holder's Soc. Sec.#:
Policy Holder's Employer:	Policy Holder's Employer:

Authorization to Treat My Child (if applicable)

List below any persons that you give permission to accompany your child for medical treatment (other than parent or guardian):

Name	Relationship to You	Telephone Number
_____	_____	_____
_____	_____	_____

Authorization, Consent and Acknowledgment

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

_____ _____

Signature of Patient or Guardian Date