ArnotHealth
Arnot Medical Services

ARNOT MEDICAL SERVICES INFORMATION FORM

Primary Provider:____________________
Other Physician(s): ____________________

Today's Date:

Preferred Pharmacy: ______________________________
Pharmacy Address: ______________________________

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Name:	SSN:(optional)	Birthdate	Sex
			_______ - _______ - _______	/ /	❑M ❑F

Race: ❑American Indian/Alaskan Native ❑Asian ❑Black/African American ❑Native Hawaiian/Other Pacific Islander ❑White

Religion: *(Optional)* ____

Ethnicity: (Optional)
❑Hispanic or Latino ❑Not Hispanic or Latino

Language Preference:
❑English ❑Spanish ❑Other

Marital Status *(circle one)*
Single Married Divorced Separated Widowed

Home Phone ( ) Mobile Phone ( ) Work Phone ( )

Email Address:

Preferred Contact Method *(please select ONLY ONE)*
❑Home Phone ❑Mobile Phone ❑Work Phone ❑Email ❑Mail

Mailing Address:

Office May Leave Message on Answering Machine ❑

City:	State:	Zip Code:

Occupation:
Employer Address:
Employer Name:
Employer Phone:

Do you have an advanced directive? ❑Yes ❑No Do you Need information? ❑Yes ❑No

IN CASE OF EMERGENCY

Name of a local friend or relative:	Phone:	Relationship to Patient:

INSURANCE INFORMATION

Please provide your insurance card to the receptionist

Person responsible for the bill:	Birthdate:	Address: *(if different)*	Home Phone:
	/ /		( )

Relationship to patient:____

Is this a Worker's Compensation Case? ❑Yes ❑No Case Managers' Name: ______________________________

Were you injured while at Work? ❑Yes ❑No Date of Injury:____________ WCB#:_______________ Claim#:_______________

Primary Insurance Company:

Subscriber's Name:	Birthdate:	Policy ID:	Group #:	Patient's Relationship to Subscriber:
	/ /			❑Self ❑Spouse ❑Child ❑Other________

Secondary Insurance Company:

Subscriber's Name:	Birthdate:	Policy ID:	Group #:	Patient's Relationship to Subscriber:
	/ /			❑Self ❑Spouse ❑Child ❑Other________

Tertiary Insurance Company:

Subscriber's Name:	Birthdate:	Policy ID:	Group #:	Patient's Relationship to Subscriber:
	/ /			❑Self ❑Spouse ❑Child ❑Other________

SIGNATURE REQUIRED BELOW:

Billing Authorization, Financial Agreement/Guarantee of Payment, Prescription Consent

The above information is true to the best of my knowledge: 1) I authorize any holder of medical information about me needed to determine these benefits payable for related services, to be released to the above company and its agents. 2) By signing this consent form I agree that this office can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. 3) I agree to promptly pay ArnotHealth: Arnot Medical Services for all charges resulting from this office appointment as the statement is presented, in accordance with federal and state law, and provide permission to Arnot Health or its designee to contact me via email, cell phone, and/or other communications methodology I provide for any activity related to treatment , payment, and/or other healthcare activities.

Patient/Guardian Signature: ______________________________ Date: ____________________