☐ Stanford ☐ Weed ☐ Fox
☐ Holmes ☐ Rhodes ☐ Merrick
☐ Nolen ☐ Repp

Patient Registration Information

Please PRINT AND complete ALL sections below!

New Patient ☐ Update Patient ☐

Patient's Personal Information

Sex: ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security # ____ - ____ - ____

Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Siblings in the same household:

_____ (name) _____ (dob)

_____ (name) _____ (dob)

_____ (name) _____ (dob)

Email: _____

Race:
☐ White ☐ African American ☐ Native American Indian/Alaskan
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other_____

Ethnicity: (Origin):
☐ Not Hispanic or Latino
☐ Hispanic or Latino

Preferred Language:
☐ English ☐ Spanish ☐ Other_____

Guarantor 1

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other_____ (relationship)

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security # ____ - ____ - ____ Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Work Phone: (____) _____

Guarantor 2

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other_____ (relationship)

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security # ____ - ____ - ____ Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Work Phone: (____) _____

Patient's Insurance Information

If newborn, hospital of birth ☐ Saline ☐ Baptist ☐ St. Vincent ☐ Other:_____

PRIMARY Insurance Name: _____ Employer Name and Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Policy Holder Date of Birth: _____ Relationship: ☐ Self ☐ Parent ☐ Other _____ Relationship

Policy #: _____ Group #: _____ Copay: $_____

SECONDARY Insurance Name: _____ Employer Name and Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holder: _____ Policy Holder Date of Birth: _____ Relationship: ☐ Self ☐ Parent ☐ Other _____ Relationship

Policy #: _____ Group #: _____ Copay: $_____

Pharmacy Information

Name: _____ Phone: (____) _____ Fax: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

(Other than Mom or Dad)

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Central Arkansas Pediatric Clinic

Financial Policy

In an effort to prevent any misunderstanding about our financial and billing policies, please take a moment to read the following information. We will gladly discuss any questions you may have about our policies.

If you do not have insurance, payment is due at the time services are rendered unless alternate payment arrangements are made with our billing staff prior to your visit. To assist you, we accept cash, checks, MasterCard, Visa, and Discover as forms of payment.

If you have insurance, we will file your primary and secondary insurance for you as a courtesy if you have provided us with your current and complete insurance information, and if you have authorized your insurance company to pay us directly. **You must realize, however, that your insurance is a contract between you and your insurance company. Payment is your responsibility.** If your insurance company requires co-payments as a part of your plan, these payments are collected during our check-in process. Please keep in mind that if a service is not a covered benefit in your insurance plan, you are responsible for the payment to us.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to **contact us promptly** for assistance in the management of your account.

In case of divorce, the parent signing this financial policy is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties in a divorce must be dealt with between those parties and does not involve Central Arkansas Pediatric Clinic.

If you have any questions about the above information, please call our **billing department at (501) 943-3015**. We are here to help you.

AUTHORIZATION: I have read and agree to the terms and conditions listed above. I hereby authorize the release of any medical information necessary to process my health insurance claim(s) and authorize payment of benefits directly to Central Arkansas Pediatric Clinic. I understand I am financially responsible to Central Arkansas Pediatric Clinic for charges not covered or denied by my insurance company. I further agree to pay the cost of collection, court cost, and other reasonable fees should they be required in the event of my non-payment. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: _____ Date: _____