Family Practice Associates

Fax (501) 778-1013 Ph (501) 778-0934

Please check one:
New patient Update name
Update address Previous form
Update insurance out of date

Patient Registration Information

Preferred Physician:
Morgan Chow Cathcart
Albey Wright-Pollich Barker
Dixon Mabry Curtis

Patient's Personal Information

Name: _____ SS#: ____ - ____ -_____ DL#: _____
Last First MI
Marital Status: S / M / D / W Date of Birth: __ / __ / ____ Sex: M / F Home phone#: (___)_____

Cell phone: (___)_____ E-mail:_____

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

Employer:_____ Work phone: (___)_____ Occupation:_____

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

Race: White African American Asian Other
Native American Indian/Alaskan Decline to answer
Native Hawaiian/Other Pacific Islander

Ethnic Group: Not Hispanic/ Latino
Hispanic/Latino
Decline to answer

Primary Language: English
Spanish
Other

Emergency Contact—List someone with a different number than your own

Name:_____ Relationship:_____

Best Phone: (___)_____ Alternate Phone: (___)_____

Preferred Pharmacy

Name: _____

Phone #:_____

If self, do not complete this section.

Guarantor Information **Relationship to patient:** □ Self □ Spouse □ Father □ Mother □ Other_____

Name: _____ SS#: ____ - ____ -_____ DL#: _____
Last First MI
Date of Birth: ___ / ___ / ____ Main phone#: (___)_____ Alternate phone: (___)_____

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

Employer:_____ Work phone: (___)_____ Occupation:_____

Patient's Insurance Information

Primary Insurance Company Name: _____ ID#: _____

Group#: _____ Insurance Address: _____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____ Main phone#: (___)_____

Subscriber's relationship to patient: □ Self □ Spouse □ Father □ Mother □ Other_____ Copay: $_____

Secondary Insurance Company Name: _____ ID#: _____

Group#: _____ Insurance Address: _____

Subscriber Name: _____ Date of Birth: ___ / ___ / ____ Main phone#: (___)_____

Subscriber's relationship to patient: □ Self □ Spouse □ Father □ Mother □ Other_____ Copay: $_____

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for services furnished me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (If this patient is a minor child, the parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce must be dealt with between those parties and does not involve Family Practice Associates.)

_____ _____
Signature Date