PATIENT INFORMATION - *PLEASE PRINT CLEARLY*

Name____
First Middle Initial Last

Address____
Street

____
City State Zip

Home Phone__________________ Mobile Phone _________________ Email ____________________________

Preferred Contact Method for Appointment Reminders: ❑ Call ❑ Text ❑ Email

Race: ________________________ Ethnicity: ____________________ Religion: _____________________

Occupation__________________Employer__________________________ Business Phone_________________

Social Security #_______________________Birthdate__________________Age_________Sex ❑ M ❑ F
Month/Day/Year

Retired- ❑ Yes ❑ No Date Retired or Eligible for Medicare_________________________

SPOUSE INFORMATION

Marital Status S M W D Spouse's Full Name____

Spouse's Employer_________________Occupation_____________ Business Phone_______________________

Spouse's Social Security #_____________________ Birthdate________________

OTHER INFORMATION

Referring Physician__________________________Primary Care Physician______________________________

In Case of Emergency, call____ Phone___________________
Name, Relationship

REFERRAL SOURCE - *HOW DID YOU HEAR ABOUT US?*

Employee referral ❑ Patient referral ❑ Physician referral ❑ Referral from friend/neighbor ❑

Please provide the name of the person we need to thank for your visit. ___________________________________

Participating provider directory ❑ Phone Book ❑ Arkansas Cardiology Website ❑ Hospital website ❑

Other____

INSURANCE INFORMATION

Primary Insurance____
Name of Insurance

Mail Claims to____ _______________________
Street City State Zip

ID#___________________________________Group # and Name____

Subscriber_______________________Social Security #_____________________DOB____________________

Subscriber Relationship to Patient ◻ Self ◻ Spouse ◻ Parent

DOES YOUR INSURANCE REQUIRE PRE-CERTIFICATION?_________PHONE #__________________

Secondary Insurance____
Name of Insurance

Mail Claims to____
Street City State Zip

ID#___________________________________Group # and Name____

Subscriber_____________________Social Security #____________________DOB_________________________

Subscriber Relationship to Patient ☐ Self ☐ Spouse ☐ Parent

The undersigned does hereby acknowledge that all information provided is true and accurate and does hereby authorize one or more of the health care providers of Arkansas Cardiology a Department of Baptist Health to administer such treatment as her or his associates may deem necessary or advisable in the diagnosis and treatment of his/her condition. The above authorization has no expiration date and will be enforced at any time the patient is treated by this clinic.