the breast center
A MANA Clinic

PATIENT REGISTRATION

www.mana.md

Internal Use Only

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mana
medical associates

PATIENT INFORMATION – Please Print

Patient Name_____

Sex: ☐ M ☐ F Date of Birth _____ Social Security # _____

Address_____ Apt. _____

City_____ State_____ Zip_____

Home Phone _____ Mobile _____

Employer _____ Work Phone _____

Please check one: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

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

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino Preferred (Primary) Language: _____

Primary Physician _____

Preferred Pharmacy_____ Street_____

Appointment Reminder: Please select how you would like to be notified of your appointment. You may select more than one option. ☐ Email ☐ Text ☐ Phone call
Message and data rates may apply for text messages. To change your preferences at anytime, you may fill out an Appointment Reminder form at the receptionist desk..

EMAIL AUTHORIZATION

Email Address _____
By providing my email address above, I hereby agree to allow MANA to contact me by email with e-newsletters, wellness reminders, health news and updates regarding health-related services provided by MANA. I understand that MANA will not share the information provided above with outside companies.

SPOUSE or PARENT (if minor) INFORMATION

Name _____ Date of Birth _____ Social Security _____

Employer _____ Address_____ Phone _____

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact _____ Relationship _____

Phone_____ Address_____ City_____ State____ Zip_____

INDICATE WHICH PHYSICIANS YOU WANT TO RECEIVE A COPY OF THIS REPORT

1. _____ 2. _____
3. _____ 4. _____

If your physician is not in the Northwest Arkansas area, please provide the receptionist with the physician's address, phone number, and fax number. *Thank you.*

SIGNATURE_____ **DATE** _____
If this form is being completed by someone other than the patient, please print your name and relationship to the patient here:

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Medical Associates of Northwest Arkansas.

SIGNATURE_____ **DATE** _____

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

_____

*If you would like to authorize MANA clinic to release information to a **family member, spouse, or personal representative**, please complete an **Individual Authorization Form** provided by the receptionist.*

➔➔ **Please complete the next page** ➔➔

Patient Name _____ D.O.B. _____

PERSON RESPONSIBLE FOR PAYMENT

☐ My self/ My spouse (skip to the next section) OR: (List Father, Mother, Guardian or other)

Responsible Party _____ DOB_____

Relationship to Patient_____ SS#_____

Phone_____ Address_____ City_____ State____ Zip_____

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist.

MEDICARE ☐ Medicare No. _____ - _____ - _____ - _____ Effective Date _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Medical Associates of Northwest Arkansas for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

PRIMARY INSURANCE _____

ID#_____ GP#_____ Phone#_____

Address_____ City_____ State_____ Zip_____

Policy Holder's Name _____ DOB_____ SS#_____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

SECONDARY INSURANCE _____

ID#_____ GP#_____ Phone#_____

Address_____ City_____ State_____ Zip_____

Policy Holder's Name _____ DOB_____ SS#_____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I hereby authorize Medical Associates of Northwest Arkansas (MANA) to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

Signed_____ Date_____

HOW DID YOU HEAR ABOUT US?

01 ☐ Recommended by a friend or family member.
02 ☐ Clinic web site, www.mana.md
03 ☐ Other web site _____
04 ☐ E-mail, Facebook or Twitter
05 ☐ Signs or location
06 ☐ Kids Directory Magazine
07 ☐ My employer
08 ☐ Citiscapes Magazine
09 ☐ Newspaper
10 ☐ Yellow Pages / phone directory
11 ☐ Received a postcard in the mail.
12 ☐ Referred by Doctor _____
13 ☐ Found the doctor listed in my Insurance directory.
14 ☐ Other *Please specify*_____

Thank you for choosing a MANA Clinic.