Patient Information Sheet Today's Date: _____

Patient's Name: _____ Patient's SS#: _____

Patient's DOB: _____ Male/Female _____ Chart#: _____

Patient's home address: _____

_____ Patient's home phone #: _____

Has your child ever been seen by our clinic? _____Y_____ N Have your child's siblings ever been seen by our clinic? _____Y_____N Sibling(s) name & DOB: _____

_____

Will patient be covered by Medicaid or ArKids? ____ Y_____ N Card#: _____

Patient's Race: (Please circle)
- White
- Asian
- Native Hawaiian or Pacific Islander
- Black or African American
- Native American
- 2 or more races

Patient's preferred language: _____
Please enter

Patient's Ethnicity: (Please circle)
- Hispanic
- Latino
- Not Hispanic or Latino

Patient's Preferred Name: _____

THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE

I authorize release of any information to my insurance company that is required to process a claim. I authorize my insurance company to make payment directly to my physician on any filed medical claims. I authorize The Children's Clinic to release my medical records to any physician who my child may be referred to or who may be involved in my child's care. I authorize treatment of the person named above and agree to pay all fees for such treatment.

Signature of Parent _____ **Date** _____

PRESCRIPTION HISTORY

I understand there may be instances when my provider needs to view my child's prescription history from external sources such as a prescription monitoring program. I give permission to view my child's prescription history.

Signature of Parent _____ **Date** _____

Patient Information Sheet Page 2

Patient's Name:_____

Mom's Name:_____ Dad's Name:_____

Mom's SS#: _____ Dad's SS#:_____

Mom's DOB: _____ Dad's DOB:_____

Mom's Cell#: _____ Dad's Cell#:_____

Mom's work#: _____ Dad's Work#:_____

Mom's employer:_____ Dad's employer:_____

Mom's Insurance:_____ Dad's Insurance:_____

Mom's Insurance Id#:_____ Dad's Insurance Id#:_____

Mom's Group Id#:_____ Dad's Group Id:_____

Mom's Ins Policy Holder:_____ Dad's Ins Policy Holder:_____

Mom's effective date:_____ Dad's effective date:_____

Mom's insurance copay?_____ Dad's insurance copay?_____

Child covered on mom's insurance? ___Y___N Child covered on dad's insurance? ___Y ___N

Emergency contact (Do NOT list parent/guardian) Name_____

Relationship to child_____Home phone:_____

Cell phone:_____ Address:_____

Portal/healow: We have a patient portal and healow app for our parents. Please supply your email and we will get you set up. Email:_____

The Children's Clinic **800 South Church, Suite 400** **Jonesboro, AR 72401** **870-935-6012**	**Web Address** **www.jbrkids.com** **To access your account from the address above, click the Patient Portal link and enter your username and password.**	**Practice Code** **BCAADA** **To access your account from the healow app, use the practice code and enter your username and password.**