Please Check One

☐ New Patient ☐ Update Patient

Patient Registration Information

Please complete **ALL** sections below!

Primary Care Provider

☐ Bone ☐ Duke
☐ Hawkins ☐ Johnson
☐ Lu ☐ Montgomery
☐ Sanders ☐ Sax

Patient's Personal Information

First Name: ______________________ Last Name: ______________________ Preferred Name: ______________

DOB: __________ Social Security #: ______________ Phone: (_____) __________ Email Address: ________ ______________

Address: ________________________________ City: ______________ State: ________ Zip: __________

List all children who live in the household:

First Name: ________________ Last Name: ________________ DOB: ____________

First Name: ________________ Last Name: ________________ DOB: ____________

First Name: ________________ Last Name: ________________ DOB: ____________

Race:

☐ White ☐ African American ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Native American Indian/ Alaskan
☐ Other________________

Ethnicity (Origin):

☐ Not Hispanic or Latino
☐ Hispanic or Latino

Preferred Language:

☐ English ☐ Spanish
☐ Other__________

Parent/ Guardian 1

Relationship to Patient: ____________

First Name: ______________________________ Last Name: ______________________________

Date of Birth: ______________ Social Security Number: ________________

Home Phone (_____) __________ Cell Phone (_____) __________ Email Address: ____________ ____________

Address: ________________________________ City: ____________ State: ______ Zip: ________

Employer Name: ____ Work Phone: (_____)__________

Parent/ Guardian 2

Relationship to Patient: ____________

First Name: ______________________________ Last Name: ______________________________

Date of Birth: ______________ Social Security Number: ________________

Home Phone (_____) __________ Cell Phone (_____) __________ Email Address: ____________ ____________

Address: ________________________________ City: ____________ State: ______ Zip: ________

Employer Name: ____ Work Phone: (_____)__________

Patient's Insurance Information

If newborn, hospital of birth: ______________________

Primary Insurance Name: ______________________________ Employer Name / Phone #: ______________

Address: ________________________________ City: ______________ State: ________ Zip: ________

Policy Holder: ______________________ Policy Holder Date of Birth: ____/____/____ Relationship: ☐ Parent ☐ Self ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $__________

Secondary Insurance Name: ______________________________ Employer Name / Phone #: ______________

Address: ________________________________ City: ______________ State: ________ Zip: ________

Policy Holder: ______________________ Policy Holder Date of Birth: ____/____/____ Relationship: ☐ Parent ☐ Self ☐ Other

Policy #: ______________________ Group #: ______________________ Copay: $__________

Pharmacy Information

Pharmacy Name: ____________________

Phone Number: ____________________

Address: ____________________

City: ____________________

Emergency Contact Information

(Other than mom or dad)

Name: ______________________________

Address: ______________________________

City: ______________ State: __________ Zip: ________

Home Phone (_____)__________ Cell Phone (_____)__________

Relationship to child: ____________________

Birth to 6 Months New Intake

Today's Date: ________________

Vital Signs:

Weight: ________lbs ____ oz

Length: _______ in. HC: _______ in

Caretaker Temp: __________

Patient Name:__________________________________ DOB: ___________ Gender: _____ Age: _______________

Name of person completing form: _________________________________ Relationship to patient: ____________________

Home / Cell Phone Number: ____________________ Name of Pharmacy Used: ____________________________________

Is your child presently taking any medications? ______NO _____ YES (***List with dosage and prescribing physician's name below)***

Medication ____________________________________ *Dose* _______________*Prescribing physician* _____________________

Medication ____________________________________ *Dose* _______________*Prescribing physician* _____________________

Medication ____________________________________ *Dose* _______________*Prescribing physician* _____________________

BIRTH HISTORY

Birth Hospital: ______________________________________

Birth Weight _____lbs ___oz Term or Premature (_____weeks) ☐ Vaginal birth or ☐ C-section Blood Type: __________

Maternal Complications? ☐ Yes ☐ No **Explain if yes** ____

Any problems after delivery? ☐ Yes ☐ No **Explain if yes**____

Was there any jaundice? ☐Yes ☐No Bilirubin level/s_______ (if known) If male, was he circumsized? ☐Yes ☐No

Was the first Hep B given in the hospital? ☐Yes ☐ No Was the newborn hearing screen passed? ☐Yes ☐No

Any problems since discharge? ☐Yes ☐ No **Explain if yes**____

FEEDINGS

Breastfeeding ?☐Yes ☐ No Any problems?☐ Yes ☐ No **If yes, please explain:** ____

Bottle feeding? ☐Yes ☐No **If Yes, Name of formula:** ____________________________ How much? _____ How often? ___________

Do you have any questions or concerns you would like to discuss today?☐Yes ☐No

Explain if yes ____

FAMILY HISTORY

Have any family members (including natural parents, grandparents, aunts, uncles, siblings) had any of the following?

☐ADD / ADHD Relationship ______________________ ☐Heart Disease < 55 yrs Relationship ______________________

☐Allergies Relationship ______________________ ☐Mental Health Issues Relationship ______________________

☐Asthma Relationship ______________________ ☐Seizure Disorder Relationship ______________________

☐Diabetes Relationship ______________________ ☐Substance Abuse Relationship ______________________

☐High Cholesterol Relationship ______________________

Additional Family History: ____

SOCIAL HISTORY

List all children in the home

Name	Relationship to child	DOB	Health Problems

What is the parent's marital status? ☐ Single ☐ Married ☐ Divorced ☐ Unmarried/Living Together

Does anyone in the home smoke? ☐Yes ☐No **Explain if yes** ____

Friends and Family Waiver

I, ____________________________, (DOB ___/___/____), authorize Arkansas Pediatric Clinic to share pertinent "Protected Health Information" with the person(s) listed below.

Please print clearly

Name:_________________________________ Phone number:________________

Name:_________________________________ Phone number:________________

Name:_________________________________ Phone number:________________

Name:_________________________________ Phone number:________________

I understand that I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member does not divulge or use the information in any way without discussing with me first.

____________________________________ ___________________________

Patient's Signature Date

16115 Saint Vincent Way, Suite 320
Little Rock, AR 72223

500 South University, Suite 317
Little Rock, AR

11749 Maumelle Blvd
North Little Rock, AR 72113

23157 I-30 Frontage Road, Suite 101
Bryant, AR 72022

Authorization for Alternate Consent

Form must be signed even if not adding names

Child's First Name: ________________________ Last Name: ________________________ DOB: _____________

I, ____ am the parent/legal guardian of the above listed child.
(Parent or Legal Guardian's Name)

I authorize Arkansas Pediatric Clinic to deliver necessary medical services to my child as determined appropriate by the physicians at Arkansas Pediatric Clinic, following receipt of written consent from any of the individuals listed below:

(Name of person you are allowing to bring the child in)	(Relationship to the child)
(Name of person you are allowing to bring the child in)	(Relationship to the child)
(Name of person you are allowing to bring the child in)	(Relationship to the child)
(Name of person you are allowing to bring the child in)	(Relationship to the child)
(Name of person you are allowing to bring the child in)	(Relationship to the child)

I acknowledge and agree to pay for all charges incurred for services provided to my child by Arkansas Pediatric Clinic, based on the consent of any of the individuals named above. I understand and agree that this authorization will remain in effect until I provide a written notice of revocation to Arkansas Pediatric Clinic.

____
Printed Name of Parent/Legal Guardian

____
Signature of Parent/Legal Guardian

____
Date

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM
PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

Member Information:

First Name ____________________ Last Name ______________________ Middle Initial ___________

Medicaid ID# ____________________Social Security # ____________________Birth Date (mm/dd/yyyy)_______________

Mailing Address _________________________ City ___________________ State ____ Zip ________

Home Phone ___________________________ Cell Phone _______________________

Email address ____

Requested New Doctor (Primary Care Provider):

1. __________________________ ____________________ _______________
Doctors first and last name Medicaid Provider ID# Date of assignment

2. __________________________ ____________________ _______________
Doctors first and last name Medicaid Provider ID# Date of assignment

3. __________________________ ____________________ _______________
Doctors first and last name Medicaid Provider ID# Date of assignment

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

Reason for Request to Assign/Change Doctor (Primary Care Provider) Choose all that apply. Select at least one.

- ○ New Member – made 1st time selection
- ○ Already patient with requested PCP
- ○ Requested PCP already sees family member
- ○ Member preference
- ○ Member moved
- ○ PCP hours didn't fit member need
- ○ Quality of care
- ○ Office wait times are too long
- ○ Takes too long to get an appointment
- ○ Office too far away/ hard to get to
- ○ Language / communication barrier
- ○ Other (please specify) ____

Signatures:

Member Signature (or Legal Guardian if a minor)____

Printed Name of Member (or Legal Guardian if a minor) ____

Date (mm/dd/yyyy) ____

Financial Policy

Thank you for choosing Arkansas Pediatric Clinic as your child's healthcare provider. We are dedicated to delivering compassionate, high-quality care to every child and their family. Timely payment of your bill helps us maintain this commitment. Please review, sign, and return our Financial Policy before your treatment begins. A copy of this policy is available upon request.

1. **Insurance**: We accept most insurance plans and will file your insurance claims provided you supply a current copy of your insurance card and accurate information at each visit. You are responsible for any balance remaining after insurance contributions, which is due within 21 days of the statement date.

2. **Copayments**: Copayments are required at the time of service as part of your agreement with your insurance provider. Failure to make copayments at the time of service may be reported to your insurance for further action. Note: Patients with Medicaid as secondary insurance must still cover any primary insurance copayments, as Medicaid does not cover these.

Proof of Insurance: All patients must complete our patient information form and provide a copy of a valid driver's license and insurance card to verify insurance.

Claims Submission: We will submit your insurance claims and assist you as much as possible to secure payment. Your insurance may request additional information from you directly, and it is your responsibility to provide this. Ultimately, the balance of your account is your responsibility, regardless of insurance payment.

Coverage Changes: Please inform us of any insurance changes before your next visit to ensure you receive your full benefits. If your insurance does not pay within 45 days, the balance will be billed to you.

Nonpayment: Balances are due within 21 days of the statement. If unpaid, reminders will be sent at timely intervals. Failure to settle your account or contact our office for payment arrangements will lead to referral to a collection agency and possible dismissal from the clinic. We offer a 90-day credit period, during which you must pay one-third of your balance or make alternative arrangements with our business office.

No Shows: Missed appointments are tracked, and multiple no-shows may result in dismissal from the clinic.

Payment Methods: We accept all major credit cards, debit cards, cash, checks, and money orders. Credit card payments can also be made over the phone. Returned checks will incur a $25 processing fee and may be referred to a third-party collection agency.

Please download the PDF version of our Financial Policy for your records and familiarize yourself with these guidelines to ensure a smooth experience at Arkansas Pediatric Clinic.

Medical records email address: medicalrecords@arped.org

AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: ____ **Date of Birth:** ________________________

1. Who is authorized to disclose the information? **Arkansas Pediatric Clinic**
2. Who is authorized to receive the information? **Name:** ____

   Complete Address: ____

   Email Address: ____

3. The specific information to be requested or released is:
   List dates of service: ____

   - ☐ All Medical Records
   - ☐ Clinic Visit Notes
   - ☐ Lab
   - ☐ Physical
   - ☐ Shot Record
   - ☐ Other: ____

4. The information is needed for:
   - ☐ Camp
   - ☐ School/Daycare
   - ☐ Insurance
   - ☐ Continuity of Care
   - ☐ Legal Reasons
   - ☐ Other: ____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations.

6. I understand that Arkansas Pediatric Clinic will be paid for the costs of copying the information to be released.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Pediatric Clinic except to the extent that action has been taken in reliance on this authorization. This authorization expires: **One year from date signed.**

9. I understand Arkansas Pediatric Clinic will release the requested information only to the entity listed above.

10. I understand that I may receive personal health information via email and I understand that the email containing the requested information is unencrypted.

PLEASE PRESENT A COPY OF A PHOTO ID

______________________________	______________________________
Signature of Patient or Representative	Date
______________________________	______________________________
Phone Number	Relationship to Patient
______________________________	______________________________
Witness	Date