



4000 Linwood Drive Suite A Paragould, AR 72450  
Phone: (870) 239-8503 Fax: (870) 236-1947

**Patient Registration (Please Complete ALL Forms)**

**Date:** \_\_\_\_\_ **Account Number:** \_\_\_\_\_

**Name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **ZIP:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Soc. Sec. No:** \_\_\_\_\_ **Sex:** M F

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Contact By:** Phone Mail Email

**Emergency Contact:** (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_ (Relationship) \_\_\_\_\_

**Local Pharmacy:** \_\_\_\_\_ **Town:** \_\_\_\_\_

**Preferred Language:** \_\_\_\_\_ **Level of Education:** \_\_\_\_\_

**Marital Status:** Married Single Widowed

**Do you smoke?:** No Yes If so, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**Race:** White Black Asian Pacific Islander Multi-Racial Hispanic Other: \_\_\_\_\_

**Responsible Party if under 18 yrs of age: Self Spouse Parent Guardian**

**Name:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **ZIP:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Soc. Sec. No:** \_\_\_\_\_ **Sex:** M F

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Contact By:** Phone Mail Email

**Insurance Information**



4000 Linwood Drive Suite A Paragould, AR 72450  
Phone: (870) 239-8503 Fax: (870) 236-1947

Primary Insurance: \_\_\_\_\_

Name of Insured: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Insured Party: Self Spouse Parent Other Insured's Date of Birth: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Name of Insured: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Insured Party: Self Spouse Parent Other Insured's Date of Birth: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_



4000 Linwood Drive Suite A Paragould, AR 72450  
Phone: (870) 239-8503 Fax: (870) 236-1947

**If you have any other insurance policies, please ask the receptionist for an additional form.**

**Please present your insurance cards to the receptionist.**

I authorize the release of all information of any kind that you may have regarding me, including but not limited to, all medical and other records, reports, bill, and other information of any kind. This authorization also specifically authorizes the release of any such information regarding drugs, alcohol, or H.I.V. I authorize the release of medical information necessary to process claims filed on my behalf.

A photocopy of this medical authorization shall be as effective as the original. This authorization is valid for 18 months from the date hereof.

**X** \_\_\_\_\_  
**Patient's/Guardian's Signature**

**X** \_\_\_\_\_  
**Insured's Signature**

\_\_\_\_\_  
**Date**

I authorize payment of medical benefits to be made directly to the supplier or provider of services performed. This authorization is valid for 18 months from the date hereof.

**X** \_\_\_\_\_  
**Patient's /Guardian's Signature**

**X** \_\_\_\_\_  
**Insured's Signature**

\_\_\_\_\_  
**Date**



4000 Linwood Drive Suite A Paragould, AR 72450  
 Phone: (870) 239-8503 Fax: (870) 236-1947

**PATIENT HISTORY (Please Complete ALL Forms)**

NAME:

DATE:

**DRUG ALLERGIES (Type of Reaction)**


**CURRENT MEDICATIONS (Name, Dose, Frequency)**


**FAMILY HISTORY**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
<b>Bleeding Disorder</b>						
<b>Diabetes</b>						
<b>Epilepsy/Convulsions</b>						
<b>Glaucoma</b>						
<b>Heart Disease</b>						
<b>High Blood Pressure</b>						
<b>Kidney Disease</b>						
<b>Lung Disease</b>						
<b>Mental Illness</b>						
<b>Stomach/Colon</b>						
<b>Stroke</b>						
<b>Thyroid Disease</b>						
<b>Cancer Type (important):</b>						
<b>Other:</b>						

**PATIENT HISTORY (Please Complete ALL Forms)**

NAME:



4000 Linwood Drive Suite A Paragould, AR 72450  
 Phone: (870) 239-8503 Fax: (870) 236-1947

**PAST MEDICAL HISTORY (Circle all that apply)**

Recent Weight Loss	Heart Attack	Irritable Bowel Syndrome
Migraine Headaches	High Blood Pressure	Constipation
Epilepsy/Convulsions	High Cholesterol	Other Bowel Problems
Eye Disease (Other than glasses)	Congestive Heart Failure	Liver/Hepatitis
Neurological	Stroke	Kidney/Bladder
Hearing Disorder	Heart Valve Disorder	Anemia
Depression	Angina – Chest Pain	Arthritis
Anxiety	Asthma	Autoimmune Disease
ADHD	COPD	Osteoporosis
Other Mental Illness	Other Lung Disease	Blood Transfusion
Recurrent Nose Bleeds	Diabetes	Stomach Ulcer
Recurrent Sinus/Throat Infections	Alcoholism	Bleeding Disorder
OTHERS:	CANCER – Type:	HIV

**PAST HOSPITALIZATION OR SURGERIES**

<b>REASON:</b>	<b>DATE:</b>

**IMMUNIZATIONS**

**HABITS**

**CANCER SCREENING**

NAME	DATE		
Influenza vaccine		Alcohol—Type/Amount:	Colorectal Cancer (e. g. Colonoscopy)
Hepatitis B		Any illegal drugs?:	Date:
Pneumonia			Normal: Yes No
Tetanus			

**FOR WOMEN ONLY**

Date of last period:	
Do you use birth control:	Yes No
Type of birth control:	
# of pregnancies:	# of live births:
# of miscarriages:	# of abortions:
Date of last PAP:	Normal: Yes No
Mammogram:	Normal: Yes No



4000 Linwood Drive Suite A Paragould, AR 72450
Phone: (870) 239-8503 Fax: (870) 236-1947

CONDITIONS OF TREATMENT

- 1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I have been informed of my rights to privacy...
2. GENERAL CONSENT TO TREATMENT AND TESTS: I desire to be treated by Doctors Health Group...
3. ASSIGNMENT OF INSURANCE BENEFITS: I certify that the information given to me in applying for payments...
4. FINANCIAL AGREEMENT: The undersigned, whether he/she is the patient or is signing as the patient's authorized representative...

The above conditions apply to services rendered by Doctors Health Group d/b/a Paragould Doctors'Clinic. Assignment of insurance benefits is valid and binding until final settlement of the account is received.

The undersigned bears the relationship of \_\_\_\_\_ to the patient.

X \_\_\_\_\_
Patient's Signature

\_\_\_\_\_
Date and Time of Signing

X \_\_\_\_\_
Patient's spouse, Representative, Agent, or Guarantor Signature

\_\_\_\_\_
DHG d/b/a Paragould Doctors' Clinic Employee Signature



4000 Linwood Drive Suite A Paragould, AR 72450
Phone: (870) 239-8503 Fax: (870) 236-1947

A. Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment.

Medicare: I request payment of authorized Medicare benefits on my behalf for any services furnished to me by Doctors Health Group d/b/a Paragould Doctors Clinic. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

B. Insured's or Authorized Person's Signature: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

C. Consent To Treatment And Tests: I consent to examinations, x-rays, blood tests, laboratory procedures, medications, and other medical services or treatments including photographic documentation, rendered by Doctors Health Group d/b/a Paragould Doctors Clinic under the instruction, orders, or directions of physician(s) and/or nurse practitioner(s). I understand that my protected health information may be released without authorization as needed for treatment, payment, or health care operations.

D. I consent to my insurance drug formulary and my medication history being checked electronically.

E. I agree that the facility, Paragould Doctors' Clinic, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

F. Please answer the following questions in order for Doctors Health Group d/b/a Paragould Doctors Clinic to accurately bill you or your Insurance/Medicare for the services you received today.

Has your Insurance/Medicare/Medicaid status changed since your last visit?

Yes [ ] No [ ]

Is today's visit the result of an accident?

Yes [ ] No [ ]

Will today's visit result in Workman's Compensation Claim?

Yes [ ] No [ ]

Patient's Signature: X \_\_\_\_\_

Date: \_\_\_\_\_

Insured/Guarantor's: X \_\_\_\_\_
Signature

Date: \_\_\_\_\_

# PARAGOULD DOCTORS' CLINIC

4000 Linwood Drive, Suite A – Paragould, AR 72450

## AUTHORIZATION TO ACCESS HEALTH INFORMATION

NAME: \_\_\_\_\_ SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Pursuant to Federal Guidelines concerning my right to confidentiality

### 1. PARTY TO RECEIVE INFORMATION:

I hereby authorize: \_\_\_\_\_  
Entity, person(s), or class of persons

To release to: \_\_\_\_\_  
Entity, person(s), or class of persons

### 2. TYPES OF INFORMATION:

The type and amount of information to be used or disclosed is as follows:

Entire medical record for \_\_\_\_\_

Date(s) of service

OR

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> History/physical    | <input type="checkbox"/> Progress notes     | <input type="checkbox"/> Itemized statement     |
| <input type="checkbox"/> Discharge summary   | <input type="checkbox"/> Nurses notes       | <input type="checkbox"/> Other (Please specify) |
| <input type="checkbox"/> Consultation report | <input type="checkbox"/> Medication records | _____   |
| <input type="checkbox"/> Operative report    | <input type="checkbox"/> Laboratory results | _____   |
| <input type="checkbox"/> Physician's orders  | <input type="checkbox"/> X-ray results      | _____   |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

### 3. METHOD OF RECORD RELEASE:

- Paper copy via mail: \_\_\_\_\_  
Mailing address
- Paper copy to be picked up in person
- Encrypted electronic copy via email: \_\_\_\_\_  
Email address
- Other (via password-protected cd) : \_\_\_\_\_  
Describe above

4. FOR THE PURPOSE OF: \_\_\_\_\_  
Describe above

### 5. REVOCATION AND EXPIRATION:

This authorization may be revoked at any time by my written consent except to the extent that action has already been taken in reliance thereon. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer (225 E. Jackson Street, Jonesboro, AR 72401; (870) 207.4422). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_ . If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.

### 6. FAILURE TO SIGN AUTHORIZATION:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions of my health information, I can contact the Privacy Officer at the above address and telephone number.

7. Paragould Doctors Clinic may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

8. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
If signed by Personal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness