ARKANSAS FAMILIES FIRST

Patient Registration

Patient:_____ _____
(LAST) (FIRST) (MI)

Address:_____
(Street) (City) (State) (Zip)

Social Security Number:_____Date of birth_____

Phone: (H)_____ (C)_____

Email Address:_____

Gender: Male___Female____ Marital Status:_____

Race:_____Ethnicity:_____Primary Language:_____

Patient Employer:_____Phone:_____

Would you like to:

Receive email reminders?___Yes___No
Receive text message reminders?___Yes___No If yes, cell carrier_____
Enroll in the patient portal? __Yes___No

Patient's Primary Care Physician:_____Phone:_____
Patient Referred by:_____Phone:_____

Emergency Contact:_____
Relationship:_____Phone:_____

Please Provide Insurance Cards and Driver's License to Our Staff

Primary Insurance _____Phone_____
Address_____
Name of policy holder_____Date of birth_____
Identification number_____Group number_____

Secondary Insurance_____Phone_____
Address_____
Name of policy holder_____Date of birth_____
Identification number_____Group number_____