# Lawrence County Family Clinic
## (Patient Paperwork)

NAME: _____ STATUS: _____ SSN: _____
(SMWD)

ADDRESS: _____
(STREET, CITY, STATE, ZIP)

RACE: _____ ETHNIC GROUP: PLEASE CIRCLE LATINO OR HISPANIC OR NOT LATINO OR HISPANIC

BIRTHDATE: _____ SEX: M ☐ F ☐ PHONE NUMBER: _____

EMAIL ADDRESS: _____

IN CASE OF EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____

BILLING NAME: (IF OTHER THAN THE PATIENT)

NAME: _____ RELATIONSHIP: _____ PHONE: _____

EMPLOYER: _____ PHONE: _____

LIST ANY DRUGS THE PATIENT IS ALLERGIC TO: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Lawrence County Family Clinic for any services furnished me by that provider. I authorize any holder of medical information about me to release to the health care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE (Patient/Authorized agent) _____ DATE: _____

I, _____, hereby authorize Lawrence County Family Clinic, P.A. to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the Physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all the charges. A photo static copy of this authorization will be valid as the original signature of the patient.

SIGNATURE: _____ DATE: _____

LAWRENCE COUNTY
**FAMILY CLINIC**
Professional Associates

S.A. SPADES, M.D.
SHAWN PEYTON, M.D.
CHARLES DAVIDSON, M.D.
CLAY SPENCER, M.D.
CASSANDRA HUNTER, M.D.

# CONSENT FOR TREATMENT

I, _____, do hereby consent to treatment by the Doctor or RNP at the Lawrence County Family Clinic, P.A.

Signature: _____ Date: _____

## FAMILY HEALTH QUESTIONNAIRE

Do you have a blood relative with any of the following? Please circle all that apply:

1. DIABETES
2. HIGH BLOOD PRESSURE
3. THYROID DISEASE
4. BREAST CANCER
5. COLON CANCER
6. FEMALE CANCER
7. MALIGNANT MELANOMA
8. OSTEOPOROSIS
9. KIDNEY STONES
10. KIDNEY DISEASE
11. GOUT
12. TB (TUBERCULOSIS)
13. SEIZURE DISORDER
14. ALLERGIES OR ASTHMA
15. HEART DISEASE

Do you have any other family history of disease: If yes, please explain below:

_____

_____

_____

_____

1210 West Main • P.O. Box 719 • Walnut Ridge, AR 72476 • (870) 886-3543 • FAX (870) 886-3252

## LAWRENCE COUNTY FAMILY CLINIC, P.A.

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I, _____, have received a copy of the above-named practices' **Notice of Privacy Practices**.

Signature of Patient: _____ Date: _____

### AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

Below is a list of persons that you give permission for our clinic to discuss and use the patient's protected health information, including condition and treatment plan, test results, prescriptions, xrays:

| Name: | Relationship to You: | Phone Number: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I understand that it is **MY** responsibility to update this list in order to keep accurate those authorized persons to receive or use this patient's information.

_____ _____

Patient Signature/Legal Representative Date