2709 West Kingshighway, Suite 6
Paragould, AR 72450
(870) 236-7272 (870) 236-7275 fax

Date______________________________ SSN_____________________________

Last Name_____________________________ MI_______ First _______________

Address____

City___________________________________ State________ Zip_____________

Phone (home)________________________ (cell)___________________________

(work)________________________ e-mail__________________________

Married / Single Male / Female Date of Birth___________________

Primary Insurance		**Secondary Insurance**	
Policy Holder (PH)		Policy Holder	
PH Sex		PH Sex	
PH SSN		PH SSN	
PH DOB		PH DOB	
ID#		ID#	
Group #		Group #	

Employment Status: employed / unemployed / retired / student

Employer:____

Employer's Address:____

Pharmacy:______________________________ Location:_____________________

Phone:_________________________________ Fax:__________________________

Emergency Contact:

Name:__________________________________ Relationship:_________________

Phone:________________________________

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Drug Allergies	Reaction (rash, nausea, etc)

Medical History

Medication	Dose / frequency	Medication	Dose / Frequency

Surgical History

Date	Procedure	Surgeon

Family History

Mother		Father	
MGMother MGFather		PGMother PGFather	
Sister(s)		Brother(s)	
Daughter(s)		Son(s)	

I give authorization for payment of insurance benefits to be made payable directly to: **Hendrix Medical Services, PLLC** and any assisting physicians/clinicians for services rendered. I understand that I am financially responsible for all charges whether or not services are covered by insurance. In the event of payment default, I agree to pay all costs of collection and reasonable attorneys fees. I hereby authorize the release of all information necessary to secure payment of benefits and also agree that a copy of this agreement shall be as valid as the original.

Patient / Legal representative Date