Date:_____

OAK PARK MEDICAL CLINIC
1301 WHITE DR
BATESVILLE, AR 72501

YES/NO

Patient Information

Preferred Pharmacy: _____

I Authorize access to obtain hospital medical records and/or doctor records:_____

I Authorize access to PBM(Pharmacy Benefit Manger):_____

Last Name: _____ First: _____Middle:_____

Date of Birth:_____Sex: M/F SSN#_____Race:_____

Marital Status: _____Primary Language: _____

Religion *(please circle one)*: Buddhist, Catholic, Hindu, Islam, Jewish, N/A, Other, Protestant, Unknown

Ethnicity *(please circle one):* Declined, Hispanic or Latino, Not Hispanic or Latino, Unknown

Address: _____ City: _____ST:_____ Zip code: _____

Home Phone: _____Primary Work: _____Cell:_____

EMAIL: _____

Preferred Communication (*please circle one*): Declined, Email, Fax, Mail, Other, Patient Portal, Phone, Text, Unknown

Employer Information

Employer: _____Phone:_____

Insurance Coverage

Primary Insurance

Insurance Company: _____ _____Policy Holder: _____

ID#:_____ Group#:_____

Secondary Insurance

Insurance Company: _____Policy Holder: _____

ID#:_____Group#:_____ __