Dear Patient,

Welcome to Reinhart Family Healthcare! Enclosed is a packet of information that gives a basic overview of our practice. It is our mission to provide quality health care in a compassionate and confidential atmosphere. It is our hope that we meet and exceed your expectations.

In compliance with federal regulations (HIPPA, Health Information Portability and Accountability Act), we are enclosing our Notice of Privacy Practices. This notice explains how your health care information may be used and how you may obtain access to this information.

Please read the enclosed information and complete the requested forms. You will find an authorization to release records to our practice. Please complete this form and forward to your previous physician as soon as possible, so that your new physician will have an opportunity to review these records prior to your appointment.

If you have any questions regarding the enclosed information or your upcoming appointment, please feel free to call our office at 870-460-6444. Our staff will be happy to assist you.

Sincerely,

Reinhart Family Healthcare

Reinhart Family Healthcare

NEW PATIENT INFORMATION

NAME _____ DOB ____/____/____ SEX: M F
(Last) (First) (MI)

ADDRESS _____

HOME PHONE_____CELL_____EMAIL _____

SOCIAL SECURITY_____ RACE_____ETHNICITY Hispanic / Non-Hispanic

RELIGION_____ LANGUAGE SPOKEN AT HOME _____

EMPLOYER/OCCUPATION:_____WORK PHONE _____

MARITAL STATUS_____ SPOUSE'S NAME _____

IF UNDER 18: FATHER'S NAME _____ EMPLOYER _____

MOTHER'S NAME_____EMPLOYER _____

EMERGENCY CONTACT PERSON _____
(Name) (Relationship) (Phone)

INSURANCE INFORMATION

#1 PRIMARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID #_____POLICY/GROUP #_____POLICY HOLDER _____

Policy Holder Date of Birth _____ Policy Holder Social Security Number: _____

#2SECONDARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID #_____POLICY/GROUP #_____POLICY HOLDER _____

Policy Holder Date of Birth _____ Policy Holder Social Security Number: _____

IS THIS A WORKMAN'S COMPENSATION (WORKPLACE) INJURY? YES_____NO _____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED FOR PROCESSING AN INSURANCE CLAIM.

FOR MEDICARE PATIENTS ONLY: I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH FINANCING ADMINISTRATION, ITS INTERMEDIARIES OR CARRIER, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

SIGNATURE_____DATE _____

Reinhart Family Healthcare

MEDICAL HISTORY

NAME_____**DOB**_____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY

	MOTHER	FATHER	SIBLING	CHILDREN	GRANDPARENT
CANCER (List Type)					
HYPERTENSION					
DIABETES					
HEART DISEASE					
THYROID DISEASE					
MENTAL HEALTH ISSUE					
SUBSTANCE ABUSE					
OTHER					

SOCIAL HISTORY

TOBACCO USE? YES_____NO_____ IF YES, WHAT TYPE?_____HOW MUCH/OFTEN? _____

ALCOHOL USE? YES_____NO_____IF YES, HOW MUCH/HOW OFTEN? _____

YOUR MEDICAL HISTORY

DO YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING CONDITIONS? CHECK ALL THAT APPLY.

ANEMIA _____ ASTHMA_____ HYPERTENSION_____ DIABETES_____DEPRESSION/ANXIETY_____

OTHER MENTAL HEALTH ISSUE_____SUBSTANCE ABUSE_____THYROID DISEASE_____HIGH CHOLESTEROL_____

CANCER (TYPE)_____HEART DISEASE _____

OTHER CONDITIONS_____

LIST ANY SPECIALISTS YOU SEE AND WHY

PHYSICIAN NAME/OFFICE	REASON

PAGE 2 **NAME**_____**DOB**_____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION_____

_____

LIST MEDICATIONS / SUPPLEMENTS YOU ARE TAKING

NAME OF MEDICATION	STRENGTH	INSTRUCTIONS
EXAMPLE: Diovan	320mg	½ tablet everyday

LIST ANY SURGERIES/HOSPITALIZATIONS/ACCIDENTS

SURGERIES/HOSPITALIZATIONS/ACCIDENTS	DATE
EXAMPLE: Tonsillectomy	1/2000

SIGNATURE_____DATE _____

(**FOR OFFICE USE ONLY)**