PREMIER FAMILY CARE
P. COREY JACKSON, M.D.
1417 GLADDEN STREET
HARRISON, AR 72601
(870) 741-0016

PATIENT INFORMATION

Patient Name_____ _____Male _____Female
First Middle Last

SS#_____ Birthdate_____ Home Phone_____ Cell Phone_____

Address_____City_____State___ Zip_____

Patient's Employer_____Work Phone_____

Please check which applies: ____Minor ____Single ____Married ____Divorced ____Widowed ____Separated

Spouse or Parent Name _____SS#_____

Spouse or Parent Employer_____Work Phone_____

Person to contact in case of emergency_____ Phone_____

RESPONSIBLE PARTY

Name of person responsible for this account_____Relationship_____

SS#_____ Birthdate_____Home Phone_____

Address_____City_____State_____Zip_____

Employer_____Work Phone_____

INSURANCE INFORMATION

Name of Insured_____Relationship_____

SS#_____ Birthdate_____

Name of Employer_____Work Phone_____

Address of Employer_____City_____State_____Zip_____

Insurance Company_____Policy#_____Group#_____

BY SIGNING BELOW:

I authorize release of any information concerning my or my child's health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. If the clinic accepts assignment with my insurance company, I authorize payment of insurance benefits otherwise payable to me to be paid directly to: P. Corey Jackson, M.D., P.A.
I understand that if my insurance company requires a referral from another physician, I am responsible for providing the referral to this clinic. If I am referred from this clinic to another physician , I am responsible for obtaining the referral before my appointment with that doctor. I am also responsible for any charges denied by my insurance company for lack of a referral or if insurance has failed to respond or make payment.
I acknowledge that I have received a copy of P. Corey Jackson, M.D., P.A., Notice of Privacy Practices.

_____ _____
Signature of Patient or Parent/Guardian if Minor Date

(PLEASE SEE REVERSE SIDE)