

#3 Medical Park Dr., Suite 201
Benton, AR 72015

Phone: 501-778-3361

FAX: 501-778-3135



www.JerryDixonMD.com

PATIENT INFORMATION

Name: _____ Sex: Male Female
LAST FIRST MIDDLE

Date of Birth: _____ Age: _____ Patient Soc. Sec # _____ Marital Status: S M W D

Address: _____
STREET APARTMENT # CITY STATE ZIP

Home Ph. () _____ Cell Ph. () _____ Race/Ethnicity _____

Email Address _____

Patient's Employer: _____ Occupation: _____

Work Ph. () _____ Work Address: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Work #: () _____ Cell #: () _____

IF PATIENT IS A MINOR, COMPLETE MOTHER AND FATHER INFORMATION:

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Employer: _____ Employer: _____

Home #: () _____ Work #: () _____ Home #: () _____ Work #: () _____

IN CASE OF EMERGENCY, Name of relative/friend NOT LIVING AT SAME ADDRESS:

Name: _____ Relationship: _____

Address: _____ Home # () _____ Cell # () _____

Name: _____ Relationship: _____

Address: _____ Home # () _____ Cell # () _____

Did your doctor send you to our clinic? : Yes : No If yes , please list the doctor's name: _____

Who is your Primary Care Doctor? : Same as above or List name: _____

Insurance Information

Primary Company: _____ : PPO Plan : HMO Effective Date: _____

Insurance Company Address: _____
STREET SUITE# CITY STATE ZIP

Policyholder's Soc. Sec #: _____ Insurance Phone:() _____

Policy #: _____ Group #: _____

Policyholder's Name: _____ Birthday: _____ Sex: : Male : Female

Secondary Company: _____ : PPO Plan : HMO Effective Date _____

Insurance Company Address: _____
STREET SUITE# CITY STATE ZIP

Policyholder's Soc. Sec #: _____ Insurance Phone:() _____

Policy #: _____ Group #: _____

Policyholder's Name: _____ Birthday: _____ Sex: : Male : Female

Insurance Authorization

I authorize the release of any medical information necessary to process my claim. I authorize payment of medical and surgical benefits to Jerry W. Dixon, MD. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature: _____

Date: _____