Clinic (circle one)
Papillion Milligan York

Urgent Care of Nebraska

Revised 04/13/2018

PATIENT REGISTRATION FORM

PATIENT INFORMATION				
Name		Middle	Date of Birth	
Gender M / F	SS# (19 & Older)	Marital Status S M D W		
Mailing Address Apt #		City	State	Zip
Cell Phone	Email Address			
Reason for Visit				
Pharmacy / Location		Primary Care Provider (Dr)		
Emergency Contact Relationship to Patient		Phone #		
Employment Status: _____Student _____Employed / Employer:_____				
PERSON RESPONSIBLE FOR THIS ACCOUNT				
Name		Relationship to Patient		
Address		City	State	Zip
DOB	SS#	Phone #		
PRIMARY INSURANCE INFORMATION:				
Name of Policy Holder		Relationship to Patient		
Address		City	State	Zip
Birth Date	SS#	Phone #		
SECONDARY INSURANCE INFORMATION:				
Name of Policy Holder		Relationship to Patient		
Address		City	State	Zip
Birth Date	SS#	Phone #		

PAYMENT AGREEMENT / INSURANCE AUTHORIZATION / ASSIGNMENT OF BENEFITS

I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or pendency of insurance claims. I authorize the release of all medical information to the above insurance carriers I provided that is pertinent to my medical care and necessary to to process claims. I assign all medical and surgical benefits to Urgent Care of Nebraska. A photocopy of this form shall be as valid as the original. I understand that I can withdraw benefit assignment at any time by notifying this office in writing.

PATIENT or LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

HOW DID YOU HEAR ABOUT US? (circle one)

Google/Yelp | Friend/Family | Referral | Social Media