Urgent Care Family Medicine of Nebraska Revised 11/25/2019

PATIENT REGISTRATION FORM

Location: Papillion York Milligan

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 #		
Patient's Employment Status Student _____ Employed_____ Employer:___________________________________					
Please fill in the information below that best describes you. We appreciate your participation. Thank you					
____White ____Black or African American ____Hispanic ____Asian ___American Indian or Alaska Native					
Language: English_______ Spanish _________ Other ______________________					
PERSON RESPONSIBLE FOR THIS ACCOUNT					
Name			Relationship to Patient		
Address		City		State	Zip
DOB	SS#		Phone #		
Responsible Party's Employer: ____					
PRIMARY INSURANCE INFORMATION:					
Name of Policy Holder			Relationship to Patient		
Address		City		State	Zip
Birth Date	SS#		Phone #		
SECONDARY INSUANCE : YES NO IF YES, PLEASE PROVIDE					

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 & Family Medicine 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 | FB/Instagram