

Patient Information

Patient Legal Name _____ Sex M F
(LAST) (FIRST) (MIDDLE)

Address _____ City _____ State _____ ZIP _____

SS# _____ Age _____ DOB _____ Race _____ Ethnicity _____

Primary Phone _____ Cell _____ Work _____

*Check Preferred Contact Number

Employment Status: Yes No Retired Employer _____

Marital Status: S M D W Other Spouse _____ Phone _____

Contact Email _____ Primary Pharmacy _____
(i.e. Walgreens 90th & Dodge)

Referring Physician _____ Family Physician _____
(please include first & last name) (please include first & last name)

Do you reside in a skilled nursing facility? No - Temp Facility Name _____ Phone _____

If Patient is a Minor or Student: School Attended _____

Mother's Name _____ Phone _____

Father's Name _____ Phone _____

Emergency Contact (Nearest relative or friend in case of emergency)

Full Name _____ Phone _____ Relationship _____

Health Insurance Information

Primary Ins. _____ Policy # _____ Group # _____

Policy Holder _____ SS# _____ DOB _____ Co-pay _____

Secondary Ins. _____ Policy # _____ Group # _____

Policy Holder _____ SS# _____ DOB _____ Co-pay _____

Responsible Party _____ SS# _____ DOB _____

Address _____ City _____ State _____ ZIP _____

Employer/Address _____ Relationship to Patient _____

Primary Phone _____ Cell _____ Work _____

*Check Preferred Contact Number

Release of Health Information I authorize MD West ONE, P.C. to release my health & billing information to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Appointment Reminders In the event I am unreachable, I authorize MD West ONE, P.C., to leave a message regarding my appointment time, changes or scheduling information on my answering machine, voicemail or with the person answering the phone.

Preferred Method of contact for appointment reminders or changes: Phone Email Text Other _____

Policy Notice Receipt of Acknowledgement (initial each)

_____ I acknowledge that I was offered a copy of the **Notice of Privacy Practices**.
initial

_____ I acknowledge that I was offered a copy and agree with the terms of the **Financial Policy**.
initial

_____ (if applicable) _____

Work Comp/Auto Accident Information

Carrier _____ Claim # _____ Date of Injury ____/____/____ Work Comp MVA

Address _____ City _____ State _____ ZIP _____

Employer Name/Address _____

Case Manager _____ Phone _____ Fax _____

Claims Adjustor _____ Phone _____ Fax _____

****Third Party Payor Agreement****

I hereby authorize MD West ONE, P.C., to furnish third party payors with any information concerning the medical care, treatment and billings. I hereby assign to MD West ONE, P.C., all payments for medical services to be rendered to me or my dependents, and I authorize direct payment for such benefits to MD West ONE, P.C., by any third party payor. I also agree that if any dispute arises between MD West ONE, P.C., and myself, the laws of the State of Nebraska shall govern, and all disputes between MD West ONE, P.C., and myself must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

Signature of patient or authorized legal guardian/agent

Date

Print Name