



**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 - Preferred Method of contact for appointment reminders or changes  Phone  Email

Employment Status:  Yes  No  Retired Employer \_\_\_\_\_

Marital Status:  S  M  D  W  Other Spouse \_\_\_\_\_ Phone \_\_\_\_\_

Contact Email \_\_\_\_\_ Primary Pharmacy \_\_\_\_\_  
(i.e. Walgreens 90<sup>th</sup> & 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  Perm Name \_\_\_\_\_ Phone \_\_\_\_\_

If Patient is a Minor or Student: School Attended \_\_\_\_\_

Mothers Name \_\_\_\_\_ Phone \_\_\_\_\_

Fathers 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 \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Employer/Address \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Primary Phone \_\_\_\_\_  Cell \_\_\_\_\_  Work \_\_\_\_\_

\*Check Preferred Contact Number

Signature of patient or authorized legal guardian/agent \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_



**GIKK ORTHO SPECIALISTS**



**Release of Health Information** I authorize MDWest One, P.C. to release my health & billing information to:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Appointment Reminders** I authorize MDWest One, P.C. in the event I am unreachable to leave a message regarding my appointment time, changes, or scheduling information on my answering machine, voice mail, or with the person answering the phone.

**Policy Notice Receipt of Acknowledgement (initial each)**

\_\_\_\_\_ I acknowledge that I was offered a copy of the **Notice of Privacy Practices**.

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

\_\_\_\_\_ *(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 MDWest One, P.C. to furnish third party payors with any information concerning the medical care, treatment, and billings. I hereby assign to MDWest 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 MDWest One, P.C. by any third party payor. I also agree that if any dispute arises between MDWest One, P.C. and me, the laws of the State of Nebraska shall govern, and all disputes between MDWest One, P.C. and me 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