OrthoNebraska

Patient Registration Information

Physician ______________________ Appt. Date ____________ Appt. Time ____________

PATIENT INFORMATION (please print)

LAST NAME	FIRST NAME	MIDDLE NAME

Gender: ☐ Male ☐ Female | SOCIAL SECURITY NUMBER | DATE OF BIRTH

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino | RACE

PREFERRED LANGUAGE | PRIMARY CARE PROVIDER

PATIENT'S ADDRESS

ZIP	CITY	STATE	COUNTY

PRIMARY PHONE NUMBER | ALTERNATE PHONE NUMBER

EMAIL ADDRESS | Marital Status: ☐ S ☐ M ☐ W ☐ D

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Student ☐ Other | RETIREMENT/DISABILITY DATE

EMPLOYER/SCHOOL

EMPLOYER/SCHOOL ADDRESS | EMPLOYER/SCHOOL PHONE NUMBER

REASON FOR VISIT | Advanced Directive? ☐ Yes ☐ No

ENCOUNTER INFORMATION (please print)

DATE & TIME OF ACCIDENT/INJURY

Is this due to a Motor Vehicle Accident? ☐ Yes ☐ No | Is this due to a Workman's Comp? ☐ Yes ☐ No

GUARANTOR (if patient is a MINOR – info for person receiving Billing Statement)

NAME | SOCIAL SECURITY NUMBER

DATE OF BIRTH | RELATIONSHIP TO PATIENT

ADDRESS

ZIP	CITY	STATE	COUNTY

PRIMARY PHONE NUMBER | ALTERNATE PHONE NUMBER

EMPLOYER | EMPLOYER PHONE NUMBER

PRIMARY INSURANCE INFORMATION (Please provide the Front Desk with Insurance Card.)

SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SUBSCRIBER'S HOME ADDRESS

EMPLOYER | EMPLOYER PHONE | ☐ Full Time ☐ Part Time

INSURANCE | POLICY NUMBER

CLAIMS ADDRESS | CITY/STATE/ZIP

SECONDARY INSURANCE INFORMATION (Please provide the Front Desk with Insurance Card.)

SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SUBSCRIBER'S HOME ADDRESS

EMPLOYER | EMPLOYER PHONE | ☐ Full Time ☐ Part Time

INSURANCE | POLICY NUMBER

CLAIMS ADDRESS | CITY/STATE/ZIP

EMERGENCY CONTACT

NAME | DATE OF BIRTH | Gender: ☐ Male ☐ Female

PRIMARY PHONE NUMBER | RELATIONSHIP TO PATIENT