

PAPILLION FAMILY MEDICINE NEW PATIENT INFORMATION

PRIMARY DOCTOR DR. MANTLER DR. NAEGELE ERIN BORN BROOKE DORWART NEW PATIENT

PERSONAL INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE _____
DOB ____/____/____ SS# ____/____/____ HM # [] _____ CELL # [] _____
ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP _____
EMAIL ADDRESS _____

OTHER INFORMATION

MARITAL STATUS **S M D W** SEX **M F** STUDENT STATUS **FULL/PART TIME** **NON-STUDENT**
EMERGENCY CONTACT NAME _____ RELATIONSHIP TO PATIENT _____
HOME PHONE # [] _____ CELL # [] _____ WORK # [] _____

EMPLOYER INFORMATION

PATIENT EMPLOYER _____ PHONE # [] _____ EXT _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE FOR INSURANCE

PRIMARY CARRIER _____ EFF DATE _____ COPAY \$ _____
POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP _____
DOB ____/____/____ SS# ____/____/____ HM # [] _____ CELL # [] _____
EMPLOYER _____ WORK # [] _____ EXT _____

SECONDARY CARRIER _____ EFF DATE _____ COPAY \$ _____
POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP _____
DOB ____/____/____ SS# ____/____/____ HM # [] _____ CELL # [] _____
EMPLOYER _____ WORK # [] _____ EXT _____

I AUTHORIZE PAPILLION FAMILY MEDICINE [PFM] TO TREAT ME, OR MY WARD, AND TO RELEASE INFORMATION NEEDED FOR MY HEALTH CARE, INCLUDING ELECTRONIC PRESCRIBING.

I HAVE INSURANCE AND ASSIGN ALL BENEFITS TO BE PAID DIRECTLY TO PFM. I ALSO AUTHORIZE THE RELEASE OF INFORMATION REQUESTED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS ASSIGNMENT.
 I HAVE NO INSURANCE COVERAGE AND RECOGNIZE THAT I AM REQUIRED TO PLACE A DEPOSIT AT THE TIME OF THE SERVICE WITH THE REMAINING BALANCE OF THE BILL TO BE PAID AS REQUESTED BY PFM.

THE PERSON RESPONSIBLE FOR ALL MEDICAL BILLS FOR THIS PATIENT IS [GUARANTOR]

NAME _____ DOB ____/____/____ SS# ____/____/____
ADDRESS _____ APT # _____ CITY _____ STATE _____ ZIP _____
HOME PHONE # [] _____ CELL # [] _____ WORK # [] _____
SIGNATURE _____ DATE _____

IN ACCORDANCE WITH NEBRASKA STATE LAW, IF YOU ARE 19 YEARS OF AGE OR YOUNGER, A PARENT OR LEGAL GUARDIAN MUST SIGN THIS FORM ON YOUR BEHALF.