PAPILLION FAMILY MEDICINE NEW PATIENT INFORMATION

PRIMARY PROVIDER ☐ DR. MANTLER ☐ DR. NAEGELE ☐ BROOKE DORWART ☐ MADDIE OLSON ☐ NEW PATIENT

PERSONAL INFORMATION **CHART #**

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.