Women's Health of Northeast NE, P.C.

PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below

PATIENT'S PERSONAL INFORMATION

NAME: _____ _____ _____
Last Name First Name Initial

Sex: ☐ Male ☐ Female SOCIAL SECURITY NUMBER: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed DATE OF BIRTH: _____ / _____ / _____

Use Guide in sleeve on clipboard to complete the following:

RACE: _____ Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined PREFERRED LANGUAGE: _____

ADDRESS: _____ Apt. #: _____ CITY: _____ STATE: ____ ZIP: _____

HOME PHONE (____) _____ CELL PHONE (____) _____ WORK PHONE: (____) _____

PREFERRED CONTACT NUMBER: ☐ HOME ☐ CELL E-mail: _____

EMPLOYER: _____ ADDRESS: _____

OK to leave a message that includes medical information on your voicemail or answering machine? ☐ YES ☐ NO

PARENT OR SPOUSE INFORMATION

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Spouse ☐ Other: _____

NAME: _____ _____ _____
Last Name First Name Initial

SOCIAL SECURITY NUMBER: _____-_____-_____ DATE OF BIRTH: _____ / _____ / _____

HOME PHONE (____) _____ CELL PHONE (____) _____ WORK PHONE: (____) _____

ADDRESS: _____ Apt. #: _____ CITY: _____ STATE: ____ ZIP: _____

EMPLOYER: _____ ADDRESS: _____ Phone #: _____

EMERGENCY CONTACT:

(OUTSIDE OF HOUSEHOLD) RELATIONSHIP TO PATIENT: ☐ Parent ☐ Sibling ☐Child ☐ Other: _____

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

SPOUSE/PARENT RELEASE

In my absence I give consent for medical information to be given to:

NAME OF SPOUSE/PARENT/OTHER _____ RELATIONSHIP TO YOU:_____

SIGNED:_____ DATE: _____

ASSIGNMENT OF BENEFITS · FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Women's Health for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. All balances are due in full once insurance has processed your claim.

I also authorize Women's Health to release any medical information necessary to process my insurance claims. Should a referral be made by any Women's Health medical provider for my continued care I authorize disclosure of any/all pertinent medical records.

Signed (Self/Parent/Guardian) _____ Date: _____

Printed Name_____

Acknowledgment of Privacy Practices

PATIENT NAME: _____

PATIENT DOB: _____

I acknowledge that I have reviewed or had the opportunity to review the Notice of Privacy Practices of Women's Health of Northeast Nebraska. I understand the Privacy Practices as outlined in the Notice of Privacy Practices.

_____ I do not object to and have not requested any limitations on any uses of disclosures of my healthcare information.

OR

_____ I request the following restrictions on uses and disclosures of my healthcare information.

_____

_____

_____

_____

I have had a chance to discuss the Notice with an office representative and my questions have been answered.

_____ _____

Date Patient Signature

_____ _____

Witness Patient's Personal Representative

If signed by a Personal Representative, please explain your relationship to the patient.

_____

Dk Word