



NEW PATIENT REGISTRATION FORM

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TO ENSURE ACCURATE INFORMATION IN OUR MEDICAL RECORD AND PROMPT FILING AND PAYMENT OF YOUR INSURANCE CLAIMS, PLEASE PRINT ALL INFORMATION BELOW.

PATIENT INFORMATION:

PATIENT LAST NAME: FIRST NAME: MI:
PATIENT SOCIAL SECURITY NUMBER: DATE OF BIRTH: SEX: M / F
PATIENT ADDRESS: (STREET) (CITY) (STATE) (ZIP)
MARITAL STATUS: S M NA W D APPOINTMENT REMINDER PHONE NUMBER:
PRIMARY CARE PHYSICIAN: REFERRING PHYSICIAN:
PATIENT HOME PHONE: PATIENT WORK PHONE:
PATIENT CELLULAR PHONE: PATIENT EMERGENCY PHONE:
EMPLOYER NAME: PHONE:

PRIMARY INSURANCE POLICY HOLDER:

**INSURANCE COMPANY NAME:
INSURANCE COMPANY POLICY ID#: INSURANCE COMPANY GROUP #:
LAST NAME: FIRST NAME: MI:
DATE OF BIRTH: SEX: MALE / FEMALE SOCIAL SECURITY NUMBER:
HOW IS THE PATIENT RELATED TO THIS POLICY HOLDER? (PLEASE CIRCLE):
SELF FEMALE SPOUSE MALE SPOUSE CHILD OTHER

SECONDARY INSURANCE POLICY HOLDER:

**INSURANCE COMPANY NAME:
INSURANCE COMPANY POLICY ID#: INSURANCE COMPANY GROUP #:
LAST NAME: FIRST NAME: MI:
DATE OF BIRTH: SEX: MALE / FEMALE SOCIAL SECURITY NUMBER:
HOW IS THE PATIENT RELATED TO THIS POLICY HOLDER? (PLEASE CIRCLE):
SELF FEMALE SPOUSE MALE SPOUSE CHILD OTHER

RELEASE AGREEMENT

BY MY SIGNATURE BELOW, I AM ENTERING INTO AN AGREEMENT WITH WESTROADS MEDICAL GROUP AS FOLLOWS:

- 1. I REQUEST THAT WESTROADS MEDICAL GROUP RENDER MEDICAL SERVICES TO ME.
2. I AUTHORIZE WESTROADS MEDICAL GROUP TO RELEASE INFORMATION REGARDING MY MEDICAL CONDITION AND TREATMENT TO MY INSURANCE COMPANY, ATTORNEY, EMPLOYER, AND/OR OTHER HEALTHCARE PROFESSIONALS INVOLVED IN MY MEDICAL CARE.
3. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES RESULTING FROM SUCH AUTHORIZED MEDICAL TREATMENT AND THAT SUCH CHARGES ARE DUE AND PAYABLE AT THE TIME OF SERVICE, UNLESS I HAVE MADE OTHER ARRANGEMENTS REGARDING A FEE PAYMENT SCHEDULE.
4. I AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO WESTROADS MEDICAL GROUP WHO WILL ADJUST THE DISALLOWED AMOUNT SHOWN ON THE EXPLANATION OF BENEFITS FOR INSURANCE COMPANIES WITH WHICH THEY HAVE A WRITTEN PARTICIPATING CONTRACT AGREEMENT.
5. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO VERIFY THE COVERAGE AND BENEFITS OF MY INSURANCE POLICY WITH "MEMBER SERVICES" (PHONE NUMBER ON BACK OF MOST CARDS) AND I WILL BE RESPONSIBLE FOR ALL CO-PAYMENTS AND DEDUCTIBLE, AND NON-COVERED SERVICES AS DESCRIBED ON MY EXPLANATION OF BENEFITS.

SIGNATURE DATE

** IF YOU ARE NOT INSURED, PLEASE ASK ABOUT OUR PAYMENT ARRANGEMENT PLAN **