



PATIENT REGISTRATION FORM

10170 NICHOLAS STREET • OMAHA, NE 68114 • PHONE (402) 391-3800 • FAX (402) 934-1678

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

PATIENT INFORMATION:

PATIENTS LAST NAME: _____ FIRST NAME: _____ MI: _____

PATIENT SOCIAL SECURITY NUMBER: _____ - _____ - _____ DATE OF BIRTH: _____ / _____ / _____ SEX: M / F

PATIENT ADDRESS: _____ (STREET)
_____ (CITY) _____ (STATE) _____ (ZIP)

PATIENT HOME PHONE: (____) _____ PATIENT CELLULAR PHONE:(____) _____

PATIENT WORK PHONE: (____) _____ PATIENT EMAIL ADDRESS: _____

MAKE APPOINTMENT REMINDER CALLS TO: HOME PHONE [] CELLULAR PHONE [] WORK PHONE []

PATIENT EMERGENCY CONTACT (NAME, PHONE NUMBER, RELATIONSHIP): _____

EMPLOYER NAME: _____ PHONE: (____) _____

MARITAL STATUS: SINGLE [] MARRIED [] DIVORCED [] WIDOWED [] NOT APPLICABLE []

RACE: CAUCASIAN [] BLACK OR AFRICAN AMERICAN [] ASIAN []
NATIVE HAWAIIAN [] AMERICAN INDIAN/ALASKA NATIVE [] OTHER PACIFIC ISLANDER []
MORE THAN ONE RACE [] REFUSED TO REPORT/UNREPORTED []

LANGUAGE: ENGLISH [] SPANISH [] OTHER _____ []

ETHNICITY: HISPANIC OR LATINO [] NOT HISPANIC OR LATINO [] REFUSED TO REPORT/UNREPORTED []

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS: _____ PHARMACY PHONE: (____) _____

*PRIMARY INSURANCE POLICY HOLDER:

**INSURANCE COMPANY NAME: _____

*SECONDARY INSURANCE POLICY HOLDER:

**INSURANCE COMPANY NAME: _____

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 _____

* A COPY OF YOUR INSURANCE CARD IS REQUIRED UPON CHECK-IN

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