

NEBRASKA SPINE CENTER LLP
PATIENT REGISTRATION

NAME: MAIDEN NAME:
CURRENT ADDRESS/PO BOX

CITY ST ZIP
TELEPHONE (HOME) (WORK) (CELL)

E-MAIL ADDRESS:

BIRTH DATE AGE SEX SS#

IN CASE OF EMERGENCY, CONTACT PHONE

* Number different from home number*

EMPLOYER: OCCUPATION

FAMILY DOCTOR: REFERRING DOCTOR:
(full name required) (full name required)

ADDRESS: ADDRESS:

PHONE: PHONE:

(If patient is under age 19, please complete this section)

RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

ADDRESS/PO BOX:

TELEPHONE (HOME) (WORK) (CELL)

SS# OCCUPATION:

EMPLOYER: EMPL ADDRESS

IF MINOR, OTHER PARENT'S NAME:

PRIMARY HEALTH INSURANCE

POLICY HOLDER'S NAME: DATE OF BIRTH:

RELATION TO PATIENT: POLICY HOLDER SS #:

NAME OF INSURANCE COMPANY:

SECONDARY HEALTH INSURANCE

POLICY HOLDER'S NAME: DATE OF BIRTH:

RELATION TO PATIENT: POLICY HOLDER SS #:

NAME OF INSURANCE COMPANY:

THIRD HEALTH INSURANCE

POLICY HOLDER'S NAME: DATE OF BIRTH:

RELATION TO PATIENT: POLICY HOLDER SS #:

NAME OF INSURANCE COMPANY:

RELEASE OF INFORMATION:

I hereby authorize Nebraska Spine Center LLP and its staff, to release to the above company(ies) or its representatives, to myself, to my primary care or referring physician(s), and to consulting physicians any information used for treatment or payment.

ASSIGNMENT OF BENEFITS

AUTHORIZATION: I authorize payment of benefits directly to Nebraska Spine Center LLP. I understand that I am financially responsible for all charges not covered by my authorization.

HIPAA PRIVACY NOTICE

The signature below acknowledges receipt of a copy of Nebraska Spine Center's Notice of Privacy Practices.

CONSENT TO MEDICAL TREATMENT

I, knowing that I have (or has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic examination procedures and x-rays and to such medical treatment by Dr., his assistants, or his designees as necessary in his judgment.

Signature: Date:

(Signature of patient or person legally authorized to consent for patient)