OrthoNebraska

Patient Registration Information

Physician _____ Appt. Date _____ Appt. Time _____

PATIENT INFORMATION (please print)

LAST NAME	FIRST NAME	MIDDLE NAME

Gender: ☐ Male ☐ Female	SOCIAL SECURITY NUMBER	DATE OF BIRTH

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	RACE

PREFERRED LANGUAGE	PRIMARY CARE PROVIDER

PATIENT'S ADDRESS

ZIP	CITY	STATE	COUNTY

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	ALTERNATE PHONE NUMBER

EMAIL ADDRESS	Marital Status: ☐ S ☐ M ☐ W ☐ D

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Student ☐ Other	RETIREMENT/DISABILITY DATE

EMPLOYER/SCHOOL

EMPLOYER/SCHOOL ADDRESS	EMPLOYER/SCHOOL PHONE NUMBER

REASON FOR VISIT	Advanced Directive? ☐ Yes ☐ No

ENCOUNTER INFORMATION (please print)

DATE & TIME OF ACCIDENT/INJURY

Is this due to a Motor Vehicle Accident? ☐ Yes ☐ No	Is this due to a Workman's Comp? ☐ Yes ☐ No

GUARANTOR (if patient is a MINOR – info for person receiving Billing Statement)

NAME	SOCIAL SECURITY NUMBER

DATE OF BIRTH	RELATIONSHIP TO PATIENT

ADDRESS

ZIP	CITY	STATE	COUNTY

PRIMARY PHONE NUMBER	CELL PHONE NUMBER

EMPLOYER	EMPLOYER PHONE NUMBER

PRIMARY INSURANCE INFORMATION (Please provide the Front Desk with Insurance Card.)

SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER

EMPLOYER	EMPLOYER PHONE NUMBER

EMPLOYER ADDRESS	☐ Full Time ☐ Part Time

INSURANCE	POLICY NUMBER

CLAIMS ADDRESS	CITY/STATE/ZIP

SECONDARY INSURANCE INFORMATION (Please provide the Front Desk with Insurance Card.)

SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER

EMPLOYER	EMPLOYER PHONE NUMBER

EMPLOYER ADDRESS	☐ Full Time ☐ Part Time

INSURANCE	POLICY NUMBER

CLAIMS ADDRESS	CITY/STATE/ZIP

EMERGENCY CONTACT

NAME	DATE OF BIRTH	Gender: ☐ Male ☐ Female

PRIMARY PHONE NUMBER	RELATIONSHIP TO PATIENT