NEBRASKA INTERNAL MEDICINE PC
770 N COTNER BLVD., SUITE 220
LINCOLN, NEBRASKA 68505

Date_____

Patient's Name_____Sex M F
Last First MI

Date of Birth_____ Marital Status_____

SS#_____-_____-_____ Drivers License #_____

Address_____
Street or PO Box City State Zip Code

Billing address, if different_____

Home Phone_____-_____-_____ May we call and/or leave a message at this number: YES____ NO____

Cell Phone _____-_____-_____ May we call and/or leave a message at this number: YES____ NO____

Work Phone _____-_____-_____ May we call and/or leave a message at this number: YES____ NO____

E-Mail Address_____
If you provide a valid email address you will receive an invitation to our patient portal. If you do not provide an email address then this will indicate you are declining access to the patient portal.

If "NO", how may we contact you?_____

Employer_____Occupation_____

Do you have Durable Power of Attorney for Health Care? Yes_____ No_____
If "YES", please provide us with a copy for your chart.
Do you have a Health Care Directive? Yes_____ No_____
If "YES", please provide us a copy for your chart.
If you have a General Power of Attorney please provide us with a copy of the document.

Do you authorize us to discuss your health care and account information with anyone else? Yes_____ No_____
If "YES", who? (i.e. – spouse, children, parents, significant other) PLEASE list below.
By checking "NO" we CANNOT speak with ANYONE, including spouse, children, caregivers, etc.

Name	Address	Phone#	Relationship
Name	Address	Phone#	Relationship
Name	Address	Phone#	Relationship

CONTINUED ON BACK

EMERGENCY CONTACT

Name_____Employer_____

Address_____
Street or PO Box City State Zip Code

Home Phone _____-_____-_____ Work Phone _____-_____-_____

Relationship_____

INSURANCE INFORMATION

Please have your insurance cards and driver's license available for the receptionist to copy.

Primary Insurance_____ Secondary Insurance_____

Name of Insured_____ Name of Insured_____

ID Number_____ ID Number_____

Group Number_____ Group Number_____

Insured's Employer_____ Insured's Employer_____

Insured's Date of Birth_____ Insured's Date of Birth_____

Do you have Medicare Part D (drug coverage)? No ___ Yes____ If yes, show your card to the receptionist and complete: ID#_____ Insurance Company_____

I hereby authorize Nebraska Internal Medicine, P.C. to release my protected health care information for treatment, payment and operations, using minimum necessary standards for payment and operations. This authorization shall remain valid until written notice is given by me revoking said authorization. I further authorize payments directly to the physician. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I understand and agree that any cellular or land line phone numbers provided by myself to this office or any of our service providers, now or in the future, may be used as a means to contact me and that this office and our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice.

I authorize Nebraska Internal Medicine P.C. the ability to securely access and aggregate my medication history data from community pharmacies and patient medication claims history from payers and pharmacy benefit managers.

Signature_____ Date_____

IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES IN THIS INFORMATION