Central Nebraska Neurology

Patient Information Sheet

DATE______________

2727 W. 2nd St., Ste 340
Hastings, Nebraska 68901
(402) 463-1250

PLEASE PRINT

Primary Physician ______________________________ Pharmacy__________ ______________________

PATIENT NAME ____________________ ____________________ __________
LAST NAME FIRST NAME MIDDLE INT

ADDRESS ______________________ CITY ____________ STATE________ ZIP ____________

AGE _____ BIRTHDATE __________ SEX M F SOCIAL SECURITY # (______) - (______) - (______)

CIRCLE ONE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

CONTACT PHONE NUMBERS:

HOME # (____) ____________________ CELL # (____) ____________________

NURSING HOME/ ASSISTED LIVING # (____) ____________________

PATIENT EMPLOYER ________________________ WORK PHONE ____________

Spouse/Responsible Party Name ______________________________

EMERGENCY CONTACT PERSON:

____
NAME PHONE NUMBER RELATIONSHIP

___YES ___ NO I give the physician/staff of CNN permission to discuss my medical information with this individual

INSURANCE POLICY HOLDER (if not patient) ______________________________
Last Name First Name Mdle Int

Policy Holders Birth Date ____________ Policy Holder S.S. # ____________________

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Pay Insurance and any other health plan to Central Nebraska Neurology, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Central Nebraska Neurology, P.C., its employees and agents TO RELEASE ALL INFORMATION; reports, and records if necessary, to secure the payment of my account; including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals and doctors. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

I acknowledge that I have been offered a copy of Central Nebraska Neurology's Notice of Privacy Practices Policy, which Describes how my health insurance information may be used or disclosed.

SIGNED: (Responsible Party) ______________________________ DATE ____________

Responsible Person if Patient is a Minor ______________________________ DATE ____________

OVER >>>>>>>>>>>>>>

PLEASE NOTIFY THE OFFICE IMMEDIATELY OF ANY CHANGE IN ADDRESS OR PHONE NUMBER

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