Patient Registration Form

Lincoln Surgical GROUP, P.C.

4740 A Street, Suite 100 | Lincoln, NE 68510-4893 | Phone:402.483.7825 | Fax :402.483.7839

PATIENT'S NAME _____ (FIRST) (MIDDLE) (LAST)

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE (____) _____ / (____) _____ / (____) _____ AGE _____ BIRTHDATE ___/___/___
HOME WORK CELL

EMAIL ADDRESS (optional) _____

OCCUPATION _____ SSN _____ MARITAL STATUS (circle) M D S W

EMPLOYER'S NAME AND ADDRESS _____ SPOUSE'S NAME _____

REFERRED BY _____ FAMILY PHYSICIAN _____

EMERGENCY CONTACT (NOT LIVING WITH YOU) _____ RELATIONSHIP _____

ADDRESS _____ PHONE # _____

DO YOU CURRENTLY HAVE A POWER OF ATTORNEY OR LIVING WILL? YES NO IF SO, PLEASE NAME: _____

REFERRED BY: ❑ YELLOW PAGES ❑ WHITE PAGES ❑ LINCOLN JOURNAL ❑ SELF ❑ FRIEND/FAMILY ❑ WEB SEARCH ❑ PHYSICIAN

MEDICAL INSURANCE INFORMATION

NAME OF **PRIMARY** INSURANCE COMPANY _____

POLICY OR I.D. # _____ GROUP # _____

NAME OF POLICY HOLDER _____ BIRTHDATE _____

NAME OF **SECONDARY** INSURANCE COMPANY

POLICY OR I.D. # _____ GROUP # _____

NAME OF POLICY HOLDER _____ BIRTHDATE _____

IS THIS WORKER'S COMP OR PERSONAL INJURY RELATED? _____

I hereby authorize Lincoln Surgical Group, P.C. as the holder of medical or other information, to release to the Social Security Administration and Centers for Medicare and Medicaid Services or it's intermediaries or carrier or any other commercial insurance company, any information needed for this or future related claim(s). I further give lifetime authorization for payment of insurance benefits to be made directly to Lincoln Surgical Group, P.C. and authorize claims to be submitted on my behalf for any bills or services furnished. I hereby acknowledge and understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize Lincoln Surgical Group, P.C. to administer medical treatment. I agree that a photocopy of this agreement shall be as valid as the Original.

I have received notice of this organization's privacy practices. DATE _____

_____ _____

Signature of Patient or Authorized Representative Signature of Parent or Legal Guardian

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