MD WEST | ONE
ORTHO • NEURO • EXCELLENCE

Patient Information

Patient Legal Name_____ Sex ☐ M ☐ F
(LAST) (FIRST) (MIDDLE)

Address _____ City_____ State_____ ZIP_____

SS#_____ Age_____ DOB_____ Race_____ Ethnicity_____

☐ Primary Phone_____ ☐ Cell_____ ☐ Work_____
***Check Preferred Contact Number**

Employment Status: ☐ Yes ☐ No ☐ Retired Employer_____

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other Spouse_____ Phone_____

Contact Email_____ Primary Pharmacy_____
(i.e. Walgreens 90th & Dodge)

Referring Physician_____ Family Physician_____
(please include first & last name) ***(please include first & last name)***

Do you reside in a skilled nursing facility? ☐No - ☐Temp ☐Facility Name _____ Phone_____

If Patient is a Minor or Student: School Attended_____

Mother's Name_____ Phone_____

Father's Name_____ Phone_____

Emergency Contact *(Nearest relative or friend in case of emergency)*

Full Name_____ Phone_____ Relationship_____

Health Insurance Information

Primary Ins._____ Policy #_____ Group #_____

Policy Holder_____ SS#_____ DOB_____ Co-pay_____

Secondary Ins._____ Policy #_____ Group #_____

Policy Holder_____ SS#_____ DOB_____ Co-pay_____

Responsible Party_____ SS#_____ DOB_____

Address _____ City_____ State_____ ZIP_____

Employer/Address _____ Relationship to Patient_____

☐ Primary Phone_____ ☐ Cell_____ ☐ Work_____
***Check Preferred Contact Number**

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Release of Health Information I authorize MD West ONE, P.C. to release my health & billing information to:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Appointment Reminders In the event I am unreachable, I authorize MD West ONE, P.C., to leave a message regarding my appointment time, changes or scheduling information on my answering machine, voicemail or with the person answering the phone.

Preferred Method of contact for appointment reminders or changes: ☐Phone ☐Email ☐Text ☐Other_____

Policy Notice Receipt of Acknowledgement (initial each)

_____ I acknowledge that I was offered a copy of the **Notice of Privacy Practices**.
initial

_____ I acknowledge that I was offered a copy and agree with the terms of the **Financial Policy.**
initial

_____ ***(if applicable)*** _____

Work Comp/Auto Accident Information

Carrier_____ Claim #_____Date of Injury____/___/____☐Work Comp ☐MVA

Address _____ City_____ State_____ ZIP_____

Employer Name/Address_____

Case Manager _____ Phone_____ Fax_____

Claims Adjustor_____ Phone_____ Fax_____

****Third Party Payor Agreement****
I hereby authorize MD West ONE, P.C., to furnish third party payors with any information concerning the medical care, treatment and billings. I hereby assign to MD West ONE, P.C., all payments for medical services to be rendered to me or my dependents, and I authorize direct payment for such benefits to MD West ONE, P.C., by any third party payor. I also agree that if any dispute arises between MD West ONE, P.C., and myself, the laws of the State of Nebraska shall govern, and all disputes between MD West ONE, P.C., and myself must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

_____ _____ _____
Signature of patient or authorized legal guardian/agent Date Print Name