

Sunny Meadow Medical Clinic

305 N 37th St Norfolk, NE 68701
P: 402.370.4100 F: 402.370.4101

Patient Information

Date _____

Circle One: Male Female

Marital Status: Single Married Divorced Widowed

First, Middle, Last Name _____ Previous Name: _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Social Security Number _____ Date of Birth _____

Email Address _____

Patient's Employer _____ Employer Phone Number (____) _____

Employer Address _____ City _____ State _____ ZIP _____

Spouse Information

First, Middle, Last Name _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Social Security Number _____ Date of Birth _____

Email Address _____

Spouse's Employer _____ Employer Phone Number (____) _____

Employer Address _____ City _____ State _____ ZIP _____

Persons to whom health/billing information may be disclosed, include spouse:

Name _____ Relationship _____ Date of Birth _____ Phone _____

Name _____ Relationship _____ Date of Birth _____ Phone _____

Name _____ Relationship _____ Date of Birth _____ Phone _____

Emergency Contact (someone not living with you)

Name _____ Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

Primary Insurance Company _____ Circle One:

Male Female Relationship to Patient: _____

Policyholder's Full Name _____

Policyholder's Address _____

Policyholder's Date of Birth _____ Social Security Number _____

Policyholder's Employer _____

Policyholder's Phone Number _____

Insurance Member ID Number _____ Insurance Group Number _____

Primary Care Physician _____ Phone Number _____

Secondary Insurance Company _____

Circle One: Male Female

Relationship to Patient: _____

Policyholder's Full Name _____

Policyholder's Address _____

Policyholder's Date of Birth _____ Social Security Number _____

Policyholder's Employer _____

Policyholder's Phone Number _____

Insurance Member ID Number _____ Insurance Group Number _____

Authorization and Release

I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize the physician to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the physician's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of services and that I am ultimately responsible for any unpaid balances. A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection, and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls that this office or any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of this communication. In the future, should I acquire a new or different cellular, landline, or email address, I agree that this consent would stay effective.

I have been offered or received a copy of the Sunny Meadow Medical Clinic Notice of Privacy

Signature _____ **Date** _____