Sunny Meadow Medical Clinic

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

Patient Information Age 18 and Under Date _____

Circle One: Male Female
First, Middle, Last Name
_____Address
_____City _____ State _____ Zip _____
Mailing Address_____City_____State_____Zip_____
Home Phone (___)_____ Cell Phone (___)_____
Social Security Number _____ Date of Birth _____

Person Responsible for Payment/Parent

Marital Status: Single Married Divorced
First, Middle, Last Name _____Relationship to patient_____
Address _____City _____ State _____ Zip _____
Mailing Address_____City_____State_____Zip_____
Home Phone (___)_____ Cell Phone (___)_____
Social Security Number _____ Date of Birth _____
Email Address _____
Parent's Employer _____ Employer Phone Number (_____)_____
Employer Address _____City _____State_____ ZIP _____

Other Parent Information

Marital Status: Single Married Divorced
First, Middle, Last Name _____Relationship to patient_____
Address _____City _____ State _____ Zip _____
Mailing Address_____City_____State_____Zip_____
Home Phone (___)_____ Cell Phone (___)_____
Social Security Number _____ Date of Birth _____
Email Address _____
Parent's Employer _____ Employer Phone Number (_____)_____
Employer Address _____City _____State_____ _ZIP_____ _____

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

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 Care Physician _____ Phone Number _____

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 _____

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 usedfor treatment, billing, collection, and other services, may use any means of communication with me. Thus, I understand and agree that anyphone 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 _____