



NEW UPDATE

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential) Date (Please check preferred contact number) PATIENT'S LAST NAME FIRST NAME MIDDLE LOCAL ADDRESS APT/LOT# CITY STATE ZIP PERMANENT ADDRESS (if Different than Local Address) PHONE SOCIAL SECURITY NUMBER DATE OF BIRTH AGE SEX: MALE FEMALE MARITAL STATUS SINGLE MARRIED WIDOWED SEPARATED DIVORCED LIFE PARTNER PREFERRED LANGUAGE ENGLISH SPANISH OTHER: ETHNICITY WHITE/CAUCASIAN HISPANIC/LATINO NON-HISPANIC AFRICAN AMERICAN ASIAN NATIVE AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER DECLINED PHARMACY NAME & ADDRESS PHARMACY NUMBER SECONDARY/DME NAME & ADDRESS SECONDARY/DME NUMBER

AUTHORIZED INDIVIDUAL

NAME RELATIONSHIP CONTACT NUMBER I UNDERSTAND THE ABOVE INDIVIDUAL IS AUTHORIZED TO RECEIVE INFORMATION REGARDING MY TREATMENT, CARE, AND ACCOUNT INFORMATION.

IN CASE OF EMERGENCY

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE RELATIONSHIP CONTACT NUMBER CHECK THIS BOX IF EMERGENCY CONTACT IS THE SAME AS YOUR AUTHORIZED INDIVIDUAL

IF THE PATIENT IS A MINOR OR STUDENT

IF PATIENT IS A MINOR, WHO MAY AUTHORIZE TREATMENT RELATIONSHIP D.O.B. S.S.# IF PATIENT IS A MINOR, WHO IS THE RESPONSIBLE PARTY RELATIONSHIP D.O.B. S.S.# HOME PHONE WORK PHONE ALTERNATIVE PHONE

INSURANCE INFORMATION

INSURANCE COMPANY NAME PHONE IS THIS THROUGH EMPLOYER? YES NO ADDRESS EFFECTIVE DATE GROUP NUMBER INSURED'S NAME INSURED'S SOCIAL SECURITY # INSURED'S D.O.B. INSURED'S I.D. NUMBER (Policy No.) CO-PAY SUBSCRIBER'S RELATIONSHIP TO PATIENT SELF SPOUSE

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY NAME GROUP NUMBER PHONE IS THIS THROUGH EMPLOYER? YES NO INSURED'S NAME D.O.B. INSURED'S I.D. NUMBER (Policy No.) RELATIONSHIP TO PATIENT

IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR INSURANCE COMPANY WITH ANY REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. IF YOUR INSURANCE PLAN REQUIRES AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN IT IS YOUR RESPONSIBILITY TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THE REQUIRED INFORMATION OR APPROPRIATE AUTHORIZATION, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY.

I AUTHORIZE THE DOCTOR TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER MEDICAL CARE. I AUTHORIZE AND REQUEST TO RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN/MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS. I HAVE BEEN MADE AWARE OF NEBRASKA PULMONARY SPECIALTIES NOTICE OF PRIVACY PRACTICES AND RECEIVE SERVICES OR SUPPLIES THAT ARE NOT COVERED BY MY INSURANCE PLAN AND I AGREE TO BE DIRECTLY RESPONSIBLE FOR THESE EXPENSES. I UNDERSTAND COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY FOR PAYMENT. ASSOCIATED COLLECTION AGENCY COSTS WILL BE YOUR RESPONSIBILITY.

PATIENT/PARENT/GUARDIAN SIGNATURE: DATE: