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____

Mothers Name________________________________ Phone ________________________________

Fathers 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________________________________ DOB____________ SS#________________

Address ________________________________ City______________ State________ ZIP__________

Employer/Address ____ Relationship to Patient______________

☐ Primary Phone____________________ ☐ Cell____________________ ☐ Work____________________
***Check Preferred Contact Number**

____ ____________ ________________________
Signature of patient or authorized legal guardian/agent Date Print Name

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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 I authorize MD West ONE, P.C. in the event I am unreachable to leave a message regarding my appointment time, changes, or scheduling information on my answering machine, voice mail, 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**.

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

____ ***(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 me, the laws of the State of Nebraska shall govern, and all disputes between MD West ONE, P.C., and me 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.

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____ _______________ ______________________________

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