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Patient Demographics

First Name: _____ **Middle Name**: _____

Last Name: _____ **Suffix**:____ **Date of Birth**: _____

Current Address: _____

Phone Number: (_____)_____ **Email**: _____

Race: White / Black or African American / American Indian or Alaska Native / Asian / Native Hawaiian or Other Pacific Islander / Other Race

Ethnicity: Hispanic or Latino / Not Hispanic or Latino **Gender**: Male / Female / Unknown

Preferred Language: English / Spanish / Other **Marital Status**: Divorced / Married / Unmarried / Widowed / Other

Who is completing this form? Self / Parent or Legal guardian / Spouse or Significant other / Other

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, via SMS/text message, or with the person answering the phone.

Preferred method(s) of contact for appointment reminders: Voice / Email / Text / Do not contact

I understand that standard text messaging and data rates may apply. I may change my preferred method of contact or unsubscribe from appointment reminders at any time.

Billing Communication Preferences

I authorize MD West One, P.C. and its billing service providers to contact me regarding my account, including billing statements, balance notifications, payment reminders, payment receipts, and other billing-related communications, using the contact information I have provided.

I agree to receive billing communications by: Email / Text / Both email and text / Paper mail only

I understand that standard text messaging and data rates may apply. Electronic communications may contain limited information regarding my account. I may change my communication preferences or unsubscribe from electronic billing communications at any time.

Insurance Information

Are you the subscriber for your insurance? Yes / No / I do not have insurance

Insurance Carrier Name: _____ **Relation to Subscriber**: Spouse / Child / Other

Subscriber's Name: _____ **Date of Birth**: _____

Secondary Insurance

Do you have secondary insurance? Yes / No **Are you the subscriber for your secondary insurance**? Yes / No / NA

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Insurance Carrier Name: _____ **Relation to Subscriber**: Spouse / Child / Other

Subscriber's Name: _____ **Date of Birth**: _____

Emergency Contact Information

Would you like to add an emergency contact? Yes / No

Emergency Contact Name: _____ **Relation to Patient**: _____

Primary Phone: (_____)_____ **Secondary Phone**: (_____)_____

If the Patient Is a Minor

Mother's Name: _____ **Mother's Phone**: (_____)_____

Father's Name: _____ **Father's Phone**: (_____)_____

Financial Guarantor Information

Financial Guarantor Name: _____ **Date of Birth**: _____

Relation to Patient: Parent / Grandparent / Spouse / Legal guardian / Other _____

Does this person live with the patient? Yes / No **Address**: _____

Phone Number: (_____)_____

Policy Notice Receipt of Acknowledgement (Initial each)

I acknowledge that I was offered a copy and agree to the following policies:

_____ Notice of Privacy Practices _____ Financial Policy _____ Pain Management Agreement

Employment Information

Employment Status: Employed / Unemployed / Self-Employed / Retired / Disabled / Student

Employer Name: _____

Facility Residence

Are you currently residing in an assisted living, skilled nursing, or rehabilitation facility? Yes / No

Facility Name: _____ **Phone Number**: (_____)_____

Release of Information

Do you authorize MD West ONE, P.C. to release your health and billing information to others? Yes / No

Authorized Individuals (Name / Relation to Patient):

1. _____ / _____

2. _____ / _____

3. _____ / _____

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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 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 shall be litigated in the appropriate court in Douglas County, Nebraska. I consent to personal jurisdiction and venue being in the appropriate court located in Douglas County, Nebraska.

Signature of Patient or Authorized Legal Guardian / Agent

Printed Name: _____

Signature: _____

Date Signed: _____