Today's Date: _____

Patient Name:_____ DOB: _____ Sex: M / F (circle one)

Address:_____ City, State, Zip:_____

Social Security #:_____ Marital Status: Single Married Divorced Widowed (circle one)

Primary Phone #: _____ Cell Home Work (circle one)

Secondary Phone #:_____ Cell Home Work (circle one)

Email Address:_____

Race: □ Caucasian □ African American □ Hispanic/Latin □ Asian □ Native American □ Other_____

Preferred Language: □ English □ Spanish □ Other_____

Occupation:_____

Insurance Information

Primary Insurance Company:_____

Policy Holder's Name:_____ Date of Birth:_____

Secondary Insurance Company:_____

Policy Holder's Name:_____ Date of Birth:_____

Emergency Contact: _____ Relationship:_____ Phone #:_____ Home Work Cell

Emergency Contact: _____ Relationship:_____ Phone #:_____ Home Work Cell

How did you hear about us? Internet Patient Referral Hospital Insurance Advertisement Physician Referral Other:_____

Acknowledgment Info: I give permission to treat and assign directly to West Omaha Family Physicians, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges not paid by my health benefits provider. I hereby authorize the use of the signature (or copy thereof) to provide necessary medical information to my insurance carrier upon their request. With my signature, I attest that I have sought the services of West Omaha Family Physicians, P.C. and/or Dr. Beer at my own will. I have not been solicited to receive these services.

_____ _____

Signature of Patient or Legal Guardian Relationship to patient

_____ _____

Patient's Name (print) Date