FOR OFFICE USE ONLY
Chart # _____
Account # _____
Taken By: _____
Prepared By: _____

York Medical Clinic, P.C.
family medicine
2114 N. Lincoln Ave., Ste. A
York, Nebraska 68467
(402) 362-5555

Date_____

PATIENT INFORMATION

Patient's Legal Name:_____ Male_____ Female ____

Nickname: _____Date of Birth: / / Age: _____

Single: _____ Married _____ Widowed: _____ Divorced: _____ Separated: _____

Social Security #: _____ - _____ - _____ Driver's License #: _____

Email Address: _____

Address: _____ Telephone: _____ Cell: _____

City, State, Zip Code: _____

Employer: _____ Work Telephone: _____

Race:
White (not Hispanic or Latino) _____
Black/African American (not Hispanic or Latino) _____
American Indian/Alaska Native _____
More than one race _____
Native Hawaiian _____
Other Pacific Islander _____
Asian _____

Ethnicity:
Hispanic or Latino _____
Not Hispanic _____

Preferred Language:
English _____
Spanish _____
American Sign Language _____
Czeh _____
Vietnamese _____
Other _____

PLEASE COMPLETE IF UNDER AGE 19

Father's Name: _____ Telephone: _____

Address: _____

Employer: _____ Work Telephone: _____

Mother's Name: _____ Telephone: _____

Address: _____

Employer: _____ Work Telephone: _____

PLEASE COMPLETE IF MARRIED

Name of Spouse: _____ Date of Birth: / / Age: _____

Employer: _____ Work Telephone: _____

Maiden Name: _____

PERSON RESPONSIBLE FOR PAYMENT

Guarantor Name: _____ Date of Birth: / / Age:_____

Employer: _____ Work Telephone: _____

Address: _____

City, State, Zip: _____ Telephone: _____

EMERGENCY CONTACT (not living with you)

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____ Telephone: _____

(OVER)

INSURANCE INFORMATION

Insurance Name: _____ ID #: _____

Insurance Billing Address: _____

Policy Holder: _____ Date of Birth: _____/_____/_____

Group #: _____ Policy Effective Date: _____

Type of Coverage: Single ____ Family ____ Other ____ (specify): _____

Do you have Medicare _____ #: _____ Effective Date: _____

Part A _____ Part B _____

Do you have Nebraska Medicaid _____ #: _____

Is Todays Visit Work Comp Related _____

ASSIGNMENT OF BENEFITS

I/We assign and authorize direct payment to York Medical Clinic, P.C. all insurance benefits to which I/we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits from settlements or awarded in judgment for any personal injuries caused by a third party.

I understand if my insurance carrier pays only a portion of York Medical Clinic's bill, the remaining portion is my responsibility. All unpaid patient balances over 60 days outstanding will be subject to late charges at 16% per annum.

I further authorize York Medical Clinic, P.C. to keep my signature on file and to bill future charges to my insurance carrier. A photocopy of this assignment shall be as valid as the original.

Name of Insured: _____

Social Security Number: _____ Birth Date: _____

Person(s) covered under this policy include(s):

NAME	BIRTH DATE	SOCIAL SECURITY NUMBER

I authorize the release of any medical or other information necessary to process this claim.

I understand that I am personally responsible for all charges whether covered by insurance or not.

_____ _____

Signature-Patient Date

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Describe Personal Representative Relationship: _____

(parent, guardian, power of attorney)

I hereby certify that I have legal authority under applicable law to make this request in behalf of the patient identified above.

_____ _____

Signature of Personal Representative Date

_____ _____

Signature-Clinic Representative Date