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