Date _____ Norfolk Medical Group at Fountain Point 402-844-8000

ADULT - age 19+

PATIENT INFORMATION

Name-Last_____First_____Middle_____
Mailing Address_____City_____St_____Zip_____
Street Address_____City_____St_____Zip_____
Home Phone (_____)_____ Cell phone (_____)_____ e-mail _____
Birthdate _____ Sex ____ Marital Status (*circle one*) Married / Single / Widowed / Divorced / Separated
Race _____ **Ethnicity (circle one)** Non-Hispanic / Hispanic / Other **Preferred Language** _____
SocSec# _____ Employment/student status (circle one) Employed / Full-time student / Part-time student / None
EMPLOYER _____ EMPLOYER phone (_____)_____
Address _____ City_____ St____ Zip_____

PREFERRED METHOD OF CONTACT (please check only one box)
□ Home phone □ Cell phone □ E-mail □ Mailing address
I authorize NMG to leave voice message on my home or cell phone: □Yes □No

SPOUSE INFORMATION

Name-Last_____ First_____ Middle_____ Birth Date _____
Mailing Address_____City_____St_____Zip_____
Street Address_____City_____St_____Zip_____
Home Phone (_____)_____ Cell (_____)_____ Soc Sec# _____ Sex ___
EMPLOYER _____ EMPLOYER phone (_____)_____
Address _____ City_____ St____ Zip_____
I authorize discussion of my NMG billing with my spouse listed above. Yes__ No __

FINANCIAL POWER of ATTORNEY (present copy to receptionist for your chart)

Name-Last_____First_____Middle_____
Mailing Address_____City_____St_____Zip_____
Home Phone (_____)_____ Cell (_____)_____

EMERGENCY CONTACT #1 list a person not living with you.

Name-Last_____ First_____ Relationship _____
Home Phone (_____)_____ Cell phone (_____)_____Work phone (_____)_____x__

EMERGENCY CONTACT #2 (if no spouse listed above)

Name-Last_____ First_____ Relationship _____
Home Phone (_____)_____ Cell phone (_____)_____Work phone (_____)_____x__

<u>Present Insurance Cards</u> to the Receptionist

Primary ins company _____ **Secondary ins company** _____
Subscriber_____**Birthdate**_____ **Subscriber** _____**Birthdate** _____

1. **I agree to be responsible for all charges incurred at NMG LLC including bad check charges.**
2. **I hereby authorize NMG LLC to furnish to the insurance company all information which they may request concerning my illness or injury. Information may also be disclosed to the referring physician/other health care providers, facilities, agencies. I hereby assign to NMG LLC the amount of money to which I am entitled for medical/surgical expenses for each claim. Insurance information not provided in a timely manner may result in patient responsibility for incurred charges because they may be past the TIMELY FILING DEADLINE.**
3. **I authorize discussion of my NMG bills with the following adults (other than spouse/POA listed above)**

Name_____ Birthdate _____ Relationship _____
Name_____ Birthdate _____ Relationship _____

Signature_____ **Printed Name** _____ **Date**_____