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

CHILD - through age 18

PATIENT INFORMATION

Name-Last________________________ First____________________ Middle_____________________
Mailing Address______________________________ City____________________ St_______ Zip________
Street Address________________________________ City___________________ St_______ Zip________
Home Phone (_____)__________________ Cell phone (_____)________________
Birthdate _________ **Sex** ____ **Race** ___________ **Ethnicity (circle one)** non-Hispanic Hispanic other
Preferred Language __________ Soc Sec # ______________ Student Status: Full-time___ Part-time ___

PARENT RESPONSIBLE For PAYING This ACCOUNT (Custodial Parent)

Name-Last______________________ First___________________ Middle_________ Birthdate _________
Mailing Address_____________________________ City_____________________ St_____ Zip__________
Street Address_____________________________ City_____________________ St_____ Zip_________
Home Phone (_____)____________ Cell phone (_____)___________ Soc Sec# _______________ Sex ___
e-mail address ____
EMPLOYER name _________________________________ EMPLOYER phone (_____)________
EMPLOYER 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

OTHER PARENT

Name-Last______________________ First___________________ Middle_________ Birthdate _________
Mailing Address_____________________________ City_____________________ St_____ Zip__________
Street Address_____________________________ City_____________________ St_____ Zip_________
Home Phone (_____)____________ Cell phone (_____)___________ Soc Sec# _______________ Sex ___
EMPLOYER name _________________________________ EMPLOYER phone (_____)________
EMPLOYER address ___________________________ City_________________ St_______ Zip__________

EMERGENCY CONTACT list a person not living with patient.

Name-Last______________________________ First____________________ Relationship _____________
Home Phone (_____)___________ Cell phone (_____)___________Work phone (_____)____________x____

Present Insurance Cards to the Receptionist and fill out the information below:

Information of PERSON WHO CARRIES PRIMARY HEALTH INSURANCE for above patient
Name ____________________________ Name of Insurance Company _______________________
Birthdate ________ Soc Sec # _______________ Patient's relationship to this person ____________
Employer name _____________________________ City______________ St ____

Information of PERSON WHO CARRIES SECONDARY HEALTH INSURANCE for above patient
Name ____________________________ Name of Insurance Company _______________________
Birthdate ________ Soc Sec # _______________ Patient's relationship to this person ____________
Employer name _____________________________ City______________ St ____

1. I hereby authorize NMG LLC to furnish to the insurance company all information which they may request concerning my child's 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 for my child. 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.
2. I agree to be responsible for all charges incurred at NMG LLC including bad check charges.
Date_________________
Signature__________________________ **Printed Name** _______________________ **Relationship** __________