

Lincoln Internal Medicine Associates
3901 Pine Lake Road, Suite 220 ~ Lincoln, NE 68516 ~ (402) 421-3240

PATIENT INFORMATION-Please Print

Name: First: _____ MI: _____ Last: _____

Address: _____

City, State, Zip: _____

Phone: _____ []Home []Work []Cell

Phone: _____ []Home []Work []Cell

Patient ID #: _____ Sex: []M []F

Date of Birth: _____

Social Security #: _____

Marital Status: []Married []Single []Divorced []Widowed

Referring Physician: _____

Primary Physician: _____

PATIENT EMPLOYMENT

[]Employed []Retired []Unemployed

Employer: _____

Phone: _____

Address: _____

City, State, Zip: _____

CONTACTS

Name, Phone & Relationship i.e. Family, Pharmacy, etc

GUARANTOR []Same as Patient

Name: _____

Address: _____

City, State, Zip: _____

GUARANTOR EMPLOYMENT

Employer: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[]Same as Patient []Same as Guarantor []Other

Insured Party: _____

Insured Phone: _____

Date of Birth: _____

Relationship to Patient: _____

Company: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

SECONDARY INSURANCE

[]Same as Patient []Same as Guarantor []Other

Insured Party: _____

Insured Phone: _____

Date of Birth: _____

Relationship to Patient: _____

Company: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

REASON FOR MEDICARE AS 2nd INSURANCE

Working Age Beneficiary or spouse with Employer Group Health Plan

No-Fault Insurance including Auto is Primary

Worker's Compensation is Primary

Other Liability Insurance is Primary

Disabled Beneficiary under age 65 with Group Health Plan

Veteran's Administration

PATIENT RELEASE

I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or any pending insurance claims. I authorize the release of all medical information pertinent to my medical care and necessary to process my insurance claims. I will assign all medical benefits to Lincoln Internal Medicine Associates. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical consent at any time by notifying this office in writing.

Patient Signature: _____ Date: _____

Parent or Legal Guardian if Minor