

Arthritis Center of Nebraska
3901 Pine Lake Road, Ste 120
Lincoln, NE 68516-5497
402-420-1212



PATIENT ACCOUNT# _____ DR _____

Family Physician _____ Referred by _____

PLEASE PRINT CLEARLY with BLACK or BLUE pen

APPOINTMENT DATE _____

PATIENT NAME _____
First MI Last

**NAME PREFERRED TO BE CALLED _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-mail address _____

TELEPHONE #'s Home _____ Work _____ Cell _____

SEX Female Male Birth date ____/____/____ Marital Status Single Married Widowed Divorced
 Transgender mo day yr Separated Domestic Partner

SOCIAL SECURITY # _____

EMPLOYER _____

OCCUPATION _____ Full-Time Part-time

IN CASE OF EMERGENCY NOTIFY:

IF MARRIED-SPOUSE

NAME _____ Work _____ Cell _____ Birth Date ____/____/____
mo day yr

ADDITIONAL EMERGENCY CONTACT NOT RESIDING WITH YOU _____

Relationship to patient _____

Home _____ Work _____ Cell _____

****THE GOVERNMENT IS REQUIRING US TO COLLECT THIS DATA - Please answer BOTH questions below about Hispanic Origin and Race ****

Are you Hispanic, Latino or Spanish in Origin? Please Note: Hispanic origins are not races.

- No, not of Hispanic, Latino or Spanish Origin
- Yes, Hispanic
- Yes, Mexican
- Yes, Mexican American
- Yes, Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Other

Please select your race:

- | | | |
|---|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Chinese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Filipino | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Japanese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Korean | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Other Race | <input type="checkbox"/> Other Pacific Islander | |

Primary Language Spoken: _____

INSURANCE INFORMATION
Please be exact in listing identification numbers

Primary Insurance Co. Name _____

ID# _____ Group # _____

Patient relationship to insured: **Self** **Spouse** **Child** **Other** _____

If relationship to insured "Other than Self" please complete below:

Policy Holder Name _____
(Insured)

Address _____

City _____ State _____ Zip _____ Phone # of Policy Holder _____

Date of Birth of Insured: _____ Employer _____

+++++

Secondary Insurance Co. Name _____

ID# _____ Group # _____

Patient relationship to insured: **Self** **Spouse** **Child** **Other** _____

If relationship to insured "Other than Self" please complete below:

Policy Holder Name _____
(Insured)

Address _____

City _____ State _____ Zip _____ Phone # of Policy Holder _____

Date of Birth of Insured _____ Employer _____

+++++

Tertiary Insurance Co. Name _____
(3rd Insurance if applicable)

ID# _____ Group # _____

Patient relationship to insured: **Self** **Spouse** **Child** **Other** _____

If relationship to insured "Other than Self" please complete below:

Policy Holder Name _____
(Insured)

Address _____

City _____ State _____ Zip _____ Phone # of Policy Holder _____

Date of Birth of Insured: _____ Employer _____

PRIOR AUTHORIZATION/REFERRAL FOR INSURANCE

It is my responsibility to obtain prior authorization and/or physician referrals if required by my insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of professional services.

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM (Please sign your name below). I hereby authorize photocopies of this form to be as valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing. I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment regardless of insurance coverage or the pendency of insurance claims.

Date _____ **X** _____

Patient's or authorized person's signature



ARTHRITIS CENTER OF NEBRASKA

Melvin A. Churchill, MD
Anne R. Lorenz, APRN

Alan J. Jacobs, MD

Rick C. Chatwell, MD

Robert M. Valente, MD

Kristina A. Tyndall, APRN

Board Certified Rheumatologists Providing Comprehensive Rheumatologic Care and Osteoporosis Evaluation

Date _____

PLEASE NOTE

We are requesting the following information in order to better serve you and to ensure the proper routing of medical reports. Please complete the following using BLACK or BLUE INK:

*It is **very important** the doctor's first and last name be listed along with the city and state.

Patient Full Name (please print): _____

City, State (please print): _____, _____

Family Physician: _____
(First Name) (Last Name) (MD, PA, NP)

City, State (please print): _____, _____

***If PA (Physician Assistant) - which Doctor does he/she practice under?**

Pharmacy Preferences:

Local Pharmacy

(Name) (Address-Example: 56th & Highway 2) (Phone #)

Mail Order Pharmacy

(Name) (Address) (Phone #)

Thank you for taking the time to provide this information to our office.



Patient Name: _____

Account #: _____

AUTHORIZATION TO RELEASE AND CONSENT TO OBTAIN HEALTH INFORMATION

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM

- I hereby authorize photocopies of the Patient Information Form to be valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing.
- I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment regardless of insurance coverage or the pending of insurance processing.
- I hereby authorize the Arthritis Center of Nebraska Providers to view the external prescription history via the RxHub service for the patient listed above.
- I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years

_____ **X** _____
Date Patient's or authorized person's signature

X _____
Relationship to patient, if not the patient

ACKNOWLEDGEMENT

PLEASE CHECK ONE AND SIGN:

I acknowledge that I am aware of **Notice of Privacy Act Practices** and decline to be given a copy of the document: _____

I request to be given a copy of the **Arthritis Center of Nebraska's Notice of Privacy Practices** document: _____

_____ **X** _____
Date Patient's or authorized person's signature



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Patient Name _____ **Account #:** _____

RELEASE OF MEDICAL AND BILLING INFORMATION (Complete this form if you wish to allow family or others access to your medical and billing information)

I, _____ do hereby authorize personnel to release information concerning any and all diagnostic studies and findings contained within my clinic chart (whether performed here or elsewhere), my billing, insurance or other account information to the family member(s)/parties listed below:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

X Patient signature: _____ **Date:** _____

Please note: This form is valid from the date signed until another form is requested by the patient.

X: MedRecords/Release of Med and Billing Info