LAKESIDE ORTHOPEDICS PC

Lakeside Office
16909 Lakeside Hills Ct #208
Omaha, Ne 68130

Midlands Office
1413 S. Washington, Suite 200
Papillion, Ne 68133

PATIENT INFORMATION

Name:

Address:

City, State, Zip:

Phone: [ ] Home [ ] Work [ ] Other

Phone: [ ] Home [ ] Work [ ] Other

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 [ ] Other

Employer:

Phone:

Address:

City, State, Zip:

CONTACTS Name, Phone & Relationship ie.: Family, Pharmacy, etc.

GUARANTOR [ ] Same as Patient

Name:

Address:

City, State, Zip:

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 SECOND 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

Release: I hereby consent to the release of information provided to, or generated by Lakeside Orthopedics, PC to my primary care physician, referring physician, physical therapist, attorney, insurance carrier(s), agency or other party with a bonafide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.

Assignment: I hereby assign medical benefits otherwise payable to me to Lakeside Orthopedics, PC. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand I am responsible for all copays, deductibles, co-insurance and balances.

Verification: I hereby verify that all the above information is true and correct as of the date signed below.

Patient Signature:_____ Date:_____

Parent or Legal Guardian if Minor