

## PATIENT INFORMATION

**(Print Legibly) Please fill in all blanks.**

**Central Nebraska Cardiology**

*Patient Name (Last, First, Middle)		*Patient Email address:	
*Street/Mailing Address:		*City:	*State:
*Home Phone: (    )                      Cell#: (    )		Patient's Sex: Male    Female	Patient's Marital Status: Married    Single    Other _____
*Birth Date:	*Language (Main)  *Ethnicity  *Race	Social Security #:	Employment Status: <input type="checkbox"/> Employed FT/PT <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student
Patient's Employer:		Employer's Phone Number: (    )	
Employer's Street Address:		City:	State:                      Zip:
Primary/Referring Physician Name: _____ Phone: _____ Address: _____		Do you have?  Living Will    Yes            No Medical Power of Attorney    Yes	
Preferred Pharmacy:  Name: _____ City: _____			
Emergency Contact:  Name _____ Phone Number _____  Address _____ Relationship to Patient: _____			
<b>RESPONSIBLE PARTY INFORMATION/SECONDARY ADDRESS:</b>			
Name (Last, First, Middle)			
Street Address:		City:	State:                      Zip:
Social Security Number: XXX-XX-_____		Phone Number: (    )	
Employer's Name:		Employer's Phone Number: (    )	
<b>PLEASE SUBMIT YOUR INSURANCE CARD TO FRONT OFFICE STAFF</b>			

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Central Nebraska Cardiology. I understand that I am financially responsible for any non-covered services co-insurance. I certify that the information provided above is true and correct to the best of my knowledge. I will notify Central Nebraska Cardiology of any changes to this information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_