



Family Medicine of Lincoln

BRYANLGH PHYSICIAN NETWORK
6825 South 27th Street , Suite 201 • Lincoln, NE 68512
(402) 477-4545 • Fax (402) 477-4842

PATIENT INFORMATION

Name: _____	Sex: Male Female
Address: _____	Date of Birth: _____
_____	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single
City, State, Zip Code: _____	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Phone: Home: _____	Social Security Number: _____
Work: _____	Primary Physician: _____
Cell: _____	Referring Provider: _____
Email: _____	

PATIENT EMPLOYMENT

Employed Retired Disabled Other

Employer: _____

Phone: _____

Address: _____

City, State, Zip Code: _____

CONTACTS

Name: _____ #: _____

Relation: _____

Name: _____ #: _____

Relation: _____

Pharmacy: _____

Pharmacy #: _____

INDIVIDUAL RESPONSIBLE FOR BILLS:

Same as Patient Other

Name: _____

Relationship to Patient: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____

Employer: _____

Work Phone: _____

Social Security #: _____

Date of Birth: _____

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
<input type="checkbox"/> Same as Patient <input type="checkbox"/> Same as Guarantor <input type="checkbox"/> Other	<input type="checkbox"/> Same as Patient <input type="checkbox"/> Same as Guarantor <input type="checkbox"/> Other
Subscriber Name: _____	Subscriber Name: _____
Address: _____	Address: _____
_____	_____
City, State, Zip Code: _____	City, State, Zip Code: _____
Phone: _____	Phone: _____
Relationship to Patient: _____	Relationship to Patient: _____
Social Security #: _____	Social Security #: _____
Date of Birth: _____	Date of Birth: _____

CONSENT

I authorize treatment of the above named patient.
I authorize the release of any medical information necessary to process insurance claims. I assign those medical and/or surgical benefits to which I am entitled, for services provided by Family Medicine of Lincoln, the BryanLGH Physician's Network. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

I agree to be financially responsible for all charges. I have read and understand this information.

Patient Signature: _____ Date: _____
Parent or Legal Guardian if Minor

Witness Signature: _____ Date: _____