



# Southeast Lincoln Family Medicine

BRYANLGH PHYSICIAN NETWORK

4424 S. 86th Street • Lincoln, NE 68526  
402-483-8500 • Fax 402-483-8501

## 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: _____	Employer: _____
Relationship to Patient: _____	Work Phone: _____
Address: _____	Social Security #: _____
_____	Date of Birth: _____
City, State, Zip Code: _____	
Home Phone: _____	

## INSURANCE INFORMATION

### PRIMARY INSURANCE

Same as Patient     Same as Guarantor     Other

Subscriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City, State, Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

### SECONDARY INSURANCE

Same as Patient     Same as Guarantor     Other

Subscriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City, State, Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 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 Southeast Lincoln Family Medicine, 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: \_\_\_\_\_