Lincoln Endoscopy Center, L.L.C. | Gastroenterology Specialties, P.C.

4545 R Street Lincoln, NE 68503 (402) 465-4545 Fax (402) 465-9011
www.gidocs.net

PATIENT REGISTRATION INFORMATION

Please PRINT AND complete ALL sections below!

Date:_____ Account # _____

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of injury: _____

PATIENT'S PERSONAL INFORMATION

Name:_____ _____ _____
Last Name First Name Middle Initial
Marital status: Single ___ Married ___ Divorced ___ Widowed ___ Sex: Male ___ Female ___
Race:_____ Ethnicity:_____ Language:_____
Street address:_____ Apt _____ City:_____
State:_____ Zip:_____ Social Security #_____ Date of Birth:_____
Home phone: ( ) _____ Cellular phone: ( ) _____
Email address: _____Driver's License: (State & Number) _____
Employer/Name of School _____Work phone: ( ) _____
Spouse's name: _____ Spouse's Employer: _____
Spouse's Work phone: ( ) _____

PATIENT/RESPONSIBLE INFORMATION

Responsible party: _____ Date of Birth: _____
Relationship to Patient: Self ____ Spouse ____ Other ____ Social Security # _____
Responsible party's home phone: ( ) _____ Work phone: ( ) _____
Address: _____ Apt #_____ City: _____ State: _____ Zip: _____
Employer's name: _____ Phone number: ( ) _____
Address: _____ Apt #_____ City: _____ State: _____ Zip: _____

PATIENT/RESPONSIBLE INFORMATION

Please present insurance cards to receptionist

PRIMARY insurance company's name:_____
Insurance address: _____ City: _____ State: _____ Zip: _____
Name of insured: _____ Date of Birth: _____
Relationship to insured: Self _ Spouse _ Child _ Other _ Insurance ID #: _____Group # _____
SECONDARY insurance company's name: _____
Insurance address: _____ City: _____ State: _____ Zip: _____
Name of insured: _____ Date of Birth: _____
Relationship to insured: Self _ Spouse _ Child _ Other _ Insurance ID #: _____Group # _____

PATIENT'S REFERRAL INFORMATION

Referred by:_____
Name (s) of other physician (s) who care for you: _____

EMERGENCY CONTACT

Name of person not living with you: _____Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number (home): ( ) _____ Phone number (work): ( ) _____

ASSIGNMENT OF BENEFITS * FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to **Gastroenterology Specialties, P.C. or Lincoln Endoscopy Center, L.L.C** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Method of Payment

Cash ____ Check ___ Mastercard___ Visa___ Discover___ American Express___