Nebraska Medicine

SERIOUS MEDICINE. EXTRAORDINARY CARE.®

PATIENT REGISTRATION SERVICES
Clarkson Tower 402-552-3251 University Tower 402-559-4222 1-800-552-8802 FAX 402-552-3368

PATIENT REGISTRATION SERVICES
Bellevue Medical Center 402-763-3045 ER 402-763-3046 FAX 402-763-3149

PATIENT PRE-REGISTRATION FORM

INSTRUCTIONS:

1. Please print clearly and complete all information on both sides.
2. If you require assistance in completing this form, please call Patient Registration Services at the above numbers.
3. Please remember to bring your insurance identification card when you come to be admitted.
4. Please contact us at the above numbers if you require any special accommodations.

MRN:			**CSN:**	
ARRIVAL DATE_____ **ARRIVAL TIME**_____ **ARRIVAL MODE**_____			**TYPE OF SERVICE** □ Surgery □ OB □ Doctor Appointment □ Scheduled Test Complaint_____	
PATIENT INFORMATION	Primary Care MD	Referring MD	Do you need an Interpreter? Yes ____ No ____ If yes, what language?	
Legal Name: Last Name, First Name, Middle Initial	Date of Birth	Sex □ M □ F	Ethnic Group □ Asian □ Black Non-Hispanic □ White Non-Hispanic □ White Hispanic □ Black Hispanic □ Native American □ Native Alaskan □ Pacific Islander □ Other	
Address: Number, Street, City, State, Zip Code	County of Residence	Home Telephone	Work Telephone	Cell Telephone
E-Mail Address	Religious Preference	Community of Faith/City	Do you want your community of faith notified? □ Yes □ No	
Marital Status □ S □ M □ W □ D □ Sep □ Life Partner	Social Security Number	Patient's Maiden Name Other Names (alias/nicknames)	Patient's Mother's Maiden name (to identify records)	
Employer	Status □ FT □ PT □ Retired □ Not Employed □ Self Employed □ Active Military Duty			

SPOUSE INFORMATION	□ **Check if address and phone are the same as spouse above**	
Legal Name: Last Name, First Name, Middle Initial	Date of Birth	Employer
Work Telephone	Status □ FT □ PT □ Retired □ Not Employed □ Self Employed □ Active Military Duty	

NEXT OF KIN INFORMATION (PERSON WHO CAN MAKE MEDICAL DECISION FOR YOU IF YOU'RE UNABLE)		
Legal Name: Last Name, First Name, Middle Initial	Address: Number, Street, City, State, Zip Code	
Home Telephone	Work Telephone	Relationship to Patient

EMERGENCY CONTACT (OTHER THAN NEXT OF KIN)			
Legal Name: Last Name, First Name, Middle Initial	Primary Telephone	Secondary Telephone	Relationship to Patient

RESPONSIBLE PARTY (ONE PERSON IN HOUSEHOLD TO RECEIVE BILLING STATEMENT)

□ Check if address and phone are the same as the patient.

Legal Name: Last Name, First Name, Middle Initial	Date of Birth	Relationship to Patient	Social Security Number

Address: Number, Street, City, State, Zip Code	Home Telephone	Employer
Work Telephone	Status □ FT □ PT □ Retired □ Not Employed □ Self Employed □ Active Military Duty	

INSURANCE INFORMATION

Medicare Policy #	Effective Date	Retirement Date

Last Inpatient Hospitalization	Date	Hospital Name	Hospital Address: Number, Street, City, State, Zip Code

Medicaid Coverage (Please check applicable box) □ Medicaid □ Share Advantage □ Primary Care Plus □ Out state Nebraska (enter the state):_____	Policy #	Effective Date

Accident/Injury/Work Comp/Information (if applicable)	Date	Time	State or Country Accident Occurred in (Motor Vehicle Accident Only)

Insurance – Name	Name of Policy Holder as listed on card	Policy #	Group #

Group Name	Employer	Effective Date

Claims Address: Number, Street, City, State, Zip Code	Customer Service/Benefits Phone #	Pre-Authorization/Hospitalization Phone #

Insurance – Name	Policy Holder	Policy #	Group #

Group Name	Employer	Effective Date

Claims Address: Number, Street, City, State, Zip Code	Customer Service/Benefits Phone #	Pre-Authorization/Hospitalization Phone #