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NAME (Please give legal name)____________________________________________________________
*(First)* *(Middle Initial)* *(Last)*

BIRTHDATE_____________________________AGE_________ SEX: M F Marital Status: M S W D

SOCIAL SECURITY # ______- ____ - ________

STREET:______________________________________CITY___________________________ZIP____________

HOME PHONE:_______________________________ WORK PHONE:______________________________________

EMPLOYER:_________________________________EMPLOYER ADDRESS:__________________________________

SPOUSE (Parent if minor):__________________________EMPLOYER:______________________________________

***********************************INSURANCE INFORMATION*******************************

(Please fill in all that apply)

I. WORKMEN'S COMP If you are filing this under workmen's comp: Date of injury or accident____________

Employer's name and complete address_____________________________________________

II. If injury was due to an accident: date of injury or accident____________________________________

Where did accident occurs: ☐ home ☐ auto ☐ school ☐ recreation ☐ other_________

III. Insurance coverage: Please check all that apply

☐ Medicare ☐ Medicaid (Welfare) ☐ BCBS ☐ UHC of the Midlands

☐ Mutual of Omaha ☐ Midlands ☐ Other __________

Copy of Insurance Card Here
(Front and Back)

Reason for today's visit (include body part, left or right):_____________________________________________________
Referred by:

☐ Physician ☐ Therapist ☐ Trainer ☐ Other Name_____________________________

Family Physician:______________________________________________________________________

***********************Authorization to release information & Pay Benefits to the physician********************

I hereby authorize NEBRASKA ORTHOPAEDIC & SPORTS MEDICINE, P.C. to release any medical information necessary to process this claim for insurance or for workmen's compensation benefits. I hereby authorize payments directly to NEBRASKA ORTHOPAEDIC & SPORTS MEDICINE, P.C. for the surgical and/or medical benefits, if any, otherwise payable to me for their services. **I understand that I am financially responsible for the charges not covered by this authorization/insurance**.

Signature____________________________________________________________Date__________________________