Patient Demographic Form

Patient Information:

Last Name:_____
First Name:_____
MI:_____Preferred Name:_____
Previous Name(s):_____
Date of Birth: ____/____/____
Gender: _____
_____
Race:_____
Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Preferred Language:_____
SSN: _____-_____-_____
Address:_____
City: _____State: _____ Zip: _____
Marital Status: ☐Single ☐Married ☐Widowed
☐Divorced ☐Other_____

Employment Status:

☐ Employed
☐ Unemployed
☐ Student
☐ Retired
☐ Other

Patient Contact Information: **Please check the box for preferred number. For minors, please list guardian phone numbers.**

☐ Cell Phone:_____
☐ Work Phone:_____
☐ Home Phone:_____

Email Address:_____

Electronic Notifications:

☐ I agree to receive text messages at the cell number listed above.
☐ I agree to receive email notifications at the email written above.

☐ Check here to be registered for our patient portal with the email listed.

Who is your Primary Care Physician?

_____

Preferred Hospital:_____
Preferred Pharmacy:_____

Emergency Contact:

Name:_____
Phone:_____
Relationship:_____
Address: _____

Legal Guardian: **Please fill in if patient is under 19**

Name: _____
SSN: _____-_____-_____
Date of Birth: ___/____/____
Sex: ☐ Male ☐ Female ☐ Other
Phone: _____
Relationship: _____
Address:_____

Guarantor Information: **Please fill this in if someone other than the patient is responsible for payment.**

Name: _____
SSN: _____-_____-_____
Date of Birth: ____/___/____
Sex: ☐ Male ☐ Female ☐ Other
Phone: _____
Relationship: _____
Address: _____
Employer Name:_____
Work Address: _____
Work Phone: _____

Please flip over to complete insurance information

Insurance Information:

Required for all patients. Please present your insurance cards to the front desk specialist

Please Check any that apply:

☐ **No Insurance -** I am personally responsible for payment of my medical bills and will pay at the time of service.

☐ **Group or Private Health Insurance -** I understand it is my responsibility to provide current insurance information to LFMG and if accurate information is not provided, I am responsible for my medical bills. It is my responsibility to understand my health plan benefits.

Policy Holder Name: _____ Patient Relationship to Policy Holder: _____

Policy Holder Birth Date: ___/___/____ Policy Holder Social Security number: ____-___-_____

Insurance Company_____ ID number _____ Group: _____

☐ **Medicare Part B or Medicare Advantage (Part C)**

☐ I have supplement insurance in addition to my Medicare.

☐ **Medicaid** Please select plan below

☐ **United Healthcare Community Plan**

☐ **Nebraska Total Care**

☐ **Molina-** *Out of Network. Please speak to Front Desk staff if this is your plan*

☐ **Workers Compensation** - My visit is the result of a work injury. If yes, please complete our Injury Questionnaire. Account will be "self-pay" if claim number and case information is not provided in a timely manner.

HIPAA ACKNOWLEDGEMENT, RELEASE and AUTHORIZATION I acknowledge that I have been offered a copy of the Notice of Privacy Practices. I understand that the privacy of any information given or sent to me is my personal responsibility and I release Lincoln Family Medical Group, P.C. from liability for any use or disclosure of that information. I authorize the release of any medical information necessary to process my insurance claims.

I am aware Lincoln Family Medical Group P.C. providers and authorized staff members may access my medical history including but not limited to electronic prescription history as it pertains to my medical treatment.

I authorize payment of benefits to Lincoln Family Medical Group, P.C. if my provider accepts the assignment or participates in my insurance plan. I understand it is my responsibility to understand my health plan benefits. If I have no insurance or my provider does not participate in my insurance plan, I take responsibility for payment of all fees for services received. I understand that payment of the portion of my bill for which I am responsible is due at the time of service and if not paid on that date could be subject to an additional billing fee. Outstanding balances may be turned over to debt collection. This would result in dismissal from ALL LFMG services.

_____ _____

Signature of Patient, (Parent or Legal Guardian) Date

_____ _____

Printed Name Relationship to patient