

# OMAHA SURGICAL CONSULTANTS, PC

DATE \_\_\_\_\_

REASON FOR SEEING DOCTOR \_\_\_\_\_ Date of injury/illness \_\_\_\_\_

State in which injury occurred \_\_\_\_\_ Was injury work related? YES NO

PATIENT LEGAL NAME \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone \_\_\_\_\_ Preferred Contact \_\_\_\_\_

Cell Phone \_\_\_\_\_ Preferred Contact \_\_\_\_\_

Work Phone \_\_\_\_\_ Preferred Contact \_\_\_\_\_

SS# \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ M \_\_\_\_\_ F Email address \_\_\_\_\_

Student Status ( ) Full time ( ) Part time School \_\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

S M D W If Married: Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

If Minor or Student (covered under parents insurance)  
Mother \_\_\_\_\_ Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Father \_\_\_\_\_ Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Referred by Self / Family / Friend / Physician (please circle)

Referring Physician \_\_\_\_\_ Address \_\_\_\_\_

Family Physician \_\_\_\_\_ Address \_\_\_\_\_

I authorize you to send clinic records to the above physicians Yes / No **Please sign** \_\_\_\_\_

## BILLING INFORMATION

Primary Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex ( ) M ( ) F

Secondary Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex ( ) M ( ) F

Responsible Party \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Assignment and Release: I hereby assign my insurance benefits to be paid directly to OSC. I also authorize the physician to release any information requested by my insurance company. I understand I am financially responsible for all charges not covered by this assignment.

**Signature** \_\_\_\_\_ Date \_\_\_\_\_