



Nebraska Orthopaedic ASSOCIATES

Orthopaedics • Sports Medicine • Joint & Hand Specialists

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TODAYS DATE _____ PHYSICIAN YOU ARE SEEING _____ CHART # _____

PRIMARY CARE PHYSICIAN _____ REFERRED TO OUR OFFICE BY _____

Last and First Name

Last and First Name

ADDRESS: _____

ADDRESS: _____

PATIENT INFORMATION

LEGAL FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME # _____ WORK # _____ CELL # _____ MARITAL STATUS _____

AGE _____ DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY # _____

EMPLOYER _____ ADDRESS _____

EMERGENCY CONTACT _____ PHONE # _____ RELATIONSHIP _____

WORKMANS COMP

IS THIS A WORK RELATED INJURY? _____ DATE OF INJURY _____ CLAIM # _____

EMPLOYER _____ CONTACT PERSON _____ PHONE # _____

CASE WORKER _____ PHONE # _____ FAX # _____

INSURED PARTY / RESPONSIBLE PARTY FOR MINOR PATIENTS

LEGAL FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMPLOYER _____ ADDRESS _____

HOME PHONE _____ WORK PHONE _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION (IF NO CARD PROVIDED)

PRIMARY INSURANCE _____ ADDRESS _____

NAME OF INSURED _____ GROUP # _____ POLICY # _____

SECONDARY INSURANCE _____ ADDRESS _____

NAME OF INSURED _____ GROUP # _____ POLICY# _____

COVERED BY MEDICARE – PLEASE COMPLETE

Is the patient a Veteran? YES ___ NO ___ If YES, did the VA refer you here for treatment? YES ___ NO ___

Does the Patient have a VA Basis Card? YES ___ NO ___ Does the Patient have a Federal Black Lung Card? YES ___ NO ___

Does the Patient have health insurance coverage through their employer or a family member? YES ___ NO ___

OFFICE USE ONLY: Verified by: _____

OUR OFFICE HOLDS THE PATIENT RESPONSIBLE FOR OBTAINING ALL WRITTEN REFERRALS FROM THEIR PRIMARY CARE PHYSICIAN PRIOR TO BEING SEEN BY OUR DOCTOR(S).

DOCTORS BUILDING SOUTH - FAX # 552-2720 OAKVIEW MEDICAL BUILDING - FAX # 637-0401

COUNCIL BLUFFS – FAX #396-4025