



**Nebraska Orthopaedic ASSOCIATES** Loess Hills Orthopaedics  
 Orthopaedics • Sports Medicine • Joint & Hand Specialists

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 SCOTT B. REYNOLDS M.D. CRAIG L. HANSEN, M.D. JOHN D. GALLIGAN M.D.

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 COMPENSATION**

IS THIS A WORK RELATED INJURY? \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_ CLAIM # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_ PHONE # \_\_\_\_\_

CASE WORKER \_\_\_\_\_ PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

**INSURED PARTY**

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 \_\_\_\_\_

**RESPONSIBLE PARTY FOR MINOR PATIENTS**

LEGAL FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ LAST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

**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