PLATTE VALLEY Medical Group

Platte Valley Medical Clinic
816 22nd Ave., Suite 100
Kearney, NE 68845-2206
USA
(308) 865-2263

PATIENT INFORMATION

NAME (Last, First, Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if different than above)

NAME (Last, First, Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-Time ☐ Part-Time				

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF INSURED	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$

CITY, STATE ZIP	PHONE	DEDUCTIBLE
		$

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY #

NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$

CITY, STATE ZIP	PHONE	DEDUCTIBLE
		$

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

CLINIC POLICY IS PAYMENT FOR SERVICES ON DAY OF SERVICE

I authorize discolsure of portions of the patient record to determine liability for payment and/or obtain reimbursement and I, thereby assign all medical/surgical benefits to which I am entitled to Platte Valley Medical Group, I understand that I am financially responsible for all charges whether or not paid by said insurance.

SIGNATURE OF PATIENT/GUARDIAN DATE