



PATIENT REGISTRATION SERVICES
 Clarkson Tower 402-552-3251 University Tower 402-559-4222 1-800-552-8802 402-552-3368 FAX

PATIENT PRE-REGISTRATION FORM

INSTRUCTIONS:

1. Please print clearly and complete all information on both sides.
2. If you require assistance in completing this form, please call Patient Registration Services at the above numbers.
3. Please remember to bring your insurance identification card when you come to be admitted.
4. Please contact us at the above numbers if you require any special accommodations.

APPOINTMENT/ADMIT DATE:			TYPE OF SERVICE <input type="checkbox"/> Surgery <input type="checkbox"/> OB <input type="checkbox"/> Doctor Appointment <input type="checkbox"/> Scheduled Test <input type="checkbox"/> Other _____		
PATIENT INFORMATION	Primary Care MD	Referring MD		Do you need an Interpreter? Yes ____ No ____ If yes, what language?	
Legal Name: Last Name, First Name, Middle Initial		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Ethnic Group <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other	
Address: Number, Street, City, State, Zip Code		County of Residence	Home Telephone	Work Telephone	Cell Telephone
E-Mail Address	Religious Preference	Community of Faith/City		Do you want your community of faith notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep <input type="checkbox"/> Life Partner	Social Security Number	Patient's Maiden Name		Patient's Mother's Maiden name (to identify records)	
		Other Names (alias/nicknames)			
Employer	Occupation	Address of Employer: Number, Street, City, State, Zip Code		Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military Duty	
SPOUSE INFORMATION			<input type="checkbox"/> Check if address and phone are the same as spouse above		
Legal Name: Last Name, First Name, Middle Initial		Date of Birth	Employer	Occupation	
Address of Employer: Number, Street, City, State, Zip Code		Work Telephone	Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military Duty		
NEXT OF KIN INFORMATION (PERSON WHO CAN MAKE MEDICAL DECISION FOR YOU IF YOU'RE UNABLE)					
Legal Name: Last Name, First Name			Address: Number, Street, City, State, Zip Code		
Home Telephone		Work Telephone		Relationship to Patient	

EMERGENCY CONTACT (OTHER THAN NEXT OF KIN)				
Legal Name: Last Name, First Name		Primary Telephone	Secondary Telephone	Relationship to Patient
RESPONSIBLE PARTY (ONE PERSON IN HOUSEHOLD TO RECEIVE BILLING STATEMENT) <input type="checkbox"/> Check if address and phone are the same as the patient.				
Legal Name: Last Name, First Name, Middle Initial		Date of Birth	Relationship to Patient	Social Security Number
Address: Number, Street, City, State, Zip Code		Home Telephone	Employer	Occupation
Address of Employer: Number, Street, City, State, Zip Code		Work Telephone	Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Active Military Duty	
INSURANCE INFORMATION				
Medicare Policy #		Effective Date	Retirement Date	
Last Inpatient Hospitalization	Date	Hospital Name	Hospital Address: Number, Street, City, State, Zip Code	
Medicaid Coverage (Please check applicable box) <input type="checkbox"/> Medicaid <input type="checkbox"/> Share Advantage <input type="checkbox"/> Primary Care Plus <input type="checkbox"/> Out state Nebraska (enter the state):			Policy #	Effective Date
Accident/Injury/Work Comp/Information (if applicable)		Date	Time	State or Country Accident Occurred in
Insurance – Name	Name of Policy Holder as listed on card	Policy #		Group #
Group Name		Employer		Effective Date
Claims Address: Number, Street, City, State, Zip Code		Customer Service/Benefits Phone #	Pre-Authorization/Hospitalization Phone #	
Insurance – Name	Policy Holder	Policy #		Group #
Group Name		Employer		Effective Date
Claims Address: Number, Street, City, State, Zip Code		Customer Service/Benefits Phone #	Pre-Authorization/Hospitalization Phone #	

Please mail the completed form to: Patient Registration Services
The Nebraska Medical Center
987530 Nebraska Medical Center
Omaha, NE 68198-7530