ELKHORN VALLEY FAMILY MEDICINE
304 East Douglas St. O'Neill, NE
Phone: 402 336-4222 Fax: 402 336-4228

NEW PATIENT FORM

PATIENT NAME:
Last _____ First_____ Middle_____
Address_____
City_____ State_____ Zip_____
Phone Number_____ Cell Phone Number_____
Gender___M or ___F Marital Status: ___Single ___Married ___Divorced ___Widowed
Date of Birth___ / ___ / _____ Social Security Number_____ / ____ / _____

EMPLOYER: _____
Address_____
City_____ State_____ Zip_____
Phone Number_____

PERSON RESPONSIBLE FOR PAYMENT_____
Address_____
City_____ State_____ Zip_____
Phone Number_____
Gender ___M or ___ F Marital Status: ___Single ___Married ___Divorced ___Widowed
Date of Birth___ / ___ / _____ Social Security Number____ / ____ / _____

INSURANCE INFORMATION

Company_____ Group Number_____

Deductible $_____ Copay $_____

Signature of Responsible Party:_____

Important:
Please bring your health insurance card and information and your Driver's License or other government issued Photo ID with you. If your first visit is covered by Workman's Compensation or Auto Insurance, please fill out the Workman's Comp/Auto Accident form and bring it as well.

EMERGENCY CONTACT(S):

Name_____

Phone Number_____

Name_____

Phone Number_____