



1101 South 70th Street Suite 203
Lincoln, NE 68510

PATIENT REGISTRATION SHEET

Last Name		First Name		MI	Birth Date		Today's Date	
Address				City		State		Zip Code
Home Phone			Cell Phone			Sex	Social Security Number	
Email				Primary Care Provider				
Preferred Hospital			Preferred Pharmacy			Referred By		
Emergency Contact #1			EMG-Home Phone		EMG-Cell Phone		Relationship	
Emergency Contact #2			EMG-Home Phone		EMG-Cell Phone		Relationship	
Emergency Contact #3			EMG-Home Phone		EMG-Cell Phone		Relationship	

PLEASE COMPLETE THE FOLLOWING IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name		First Name		MI	Relationship to Patient			
Address				City		State		Zip Code
Home Phone			Cell Phone			Sex	Social Security Number	

PRIMARY INSURANCE

SECONDARY INSURANCE

Subscriber's Name		Sex M F	Subscriber's Name		Sex M F		
Subscriber Address		ID Number		Subscriber Address		ID Number	
Subscriber's Birth Date		Group Number		Subscriber's Birth Date		Group Number	
Patient's Relation to Subscriber				Patient's Relation to Subscriber			

I authorize the release of any medical information necessary to process medical insurance claims for services rendered.

Signed _____ Date: _____

I authorize and request medical insurance benefits to be paid directly to New Life Clinic

Signed _____ Date: _____

Please complete this entire form, if possible. This information will be used not only for registration information, but also for patient check in and billing purposes. Thank you very much for you time.