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	Employer		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

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

SECONDARY INSURANCE

Subscriber's Name	Sex M F
Subscriber Address	ID Number
Subscriber's Birth Date	Group Number
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. ***