Gage County Medical Clinic **Phone 402-228-3436**
1101 North 10th St, Beatrice, NE 68310 **OFFICE FAX: 402-223-4515**

PATIENT INFORMATION:

Patient's **LEGAL** Name: _____ Sex: Male [ ] Female [ ] Age: _____

Patient DOB (date of birth): _____ Patient Social Security #: _____

Marital Status: Married [ ] Single [ ] Divorced [ ] Widowed [ ] Spouse Name: _____

Race: [ ] White [ ] Black [ ] Asian [ ] Indian/Alaskan [ ] Other/Multiple **Ethnicity:** [ ] Hispanic [ ] Non-Hispanic

Preferred Language: [ ] English [ ] Spanish [ ] Other _____ **Reminder Preference:** [ ] Printed [ ] Electronic [ ] Mail

Patient Street Address: _____

City/State/Zip: _____

Mailing Address, if Different: _____

Primary Phone: _____ E-mail Address: _____

Alternate Phone: _____ Spouse Phone: _____

Employer Name/Occupation: _____ Work Phone: _____

Spouse's Employer: _____ Work Phone: _____

If patient is a minor, does child live with: mother [ ] father [ ] both [ ]. If patient is a minor, please complete the following:

Mother's Full Name: _____ Father's Full Name: _____

DOB: _____ SS#: _____ DOB: _____ SS#: _____

Address (if different from patient): _____ Address (if different from patient): _____

_____ _____

City/State/Zip: _____ City/State/Zip: _____

Phone: _____ Phone: _____

Employer: _____ Employer: _____

Work Phone: _____ Work Phone: _____

If patient has a legal guardian, please complete the following (PLEASE PROVIDE DOCUMENTATION):

Legal Guardian Name: _____ Relationship to Patient: _____

DOB: _____ Social Security #: _____ Employer: _____

Mailing Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

ALL PATIENTS: INSURANCE INFORMATION: You must provide insurance cards at time of visits.

Primary Insurance: [ ] Medicare [ ] BCBS [ ] Midlands Choice [ ] Coventry [ ] UHC [ ] Aetna [ ] Medicaid [ ] Other _____

Subscriber Full Name: _____ DOB: _____ SS#: _____

Secondary Insurance: [ ] Medicare [ ] BCBS [ ] Midlands Choice [ ] Coventry [ ] UHC [ ] Aetna [ ] Medicaid [ ] Other _____

Subscriber Full Name: _____ DOB: _____ SS#: _____

If no insurance, please check here [ ]. Financial assistance available upon request. Please ask for application.

EMERGENCY CONTACT/NEXT OF KIN: (who we may release general medical condition and diagnosis to):

Name: _____ Relationship to patient: _____

Phone: _____ Address: _____

OTHER CONTACT INFORMATION: ***(not living with patient)*** **who general medical condition/diagnosis can be released to):**

Name: _____ Relationship to patient: _____

Phone: _____ Address: _____

Signed:_____ Date: _____