Midwest Regional Health Services

YOUR HOME FOR BETTER HEALTH

Today's Date: _____

Patient Name: _____ Patient DOB: _____

Address: _____ City, State, Zip: _____

Social Security #: _____ Marital Status: Married/Single/Divorced/Widowed (Circle One)

Primary Phone: _____ (Circle One) Home Work Cell

Secondary Phone: _____ (Circle One) Home Work Cell

Email Address: _____

Billing Address: ☐ Check if address is same as patient Name: _____

Address: _____ City, State, Zip:_____

Preferred ***Contact Method***: E-mail/Telephone (Circle One)

Preferred ***Language***: English/Spanish Other_____

Race: Caucasian/African American/Hispanic/Asian/Native American Other_____

Ethnicity: Hispanic or Latino/Patient Declined/State Prohibited/Not Hispanic or Latino

Primary Insurance Company: _____

Policy Holder's name_____ Date of Birth _____ SSN _____

Secondary Insurance Company: _____

Policy Holder's name_____ Date of Birth _____SSN _____

Emergency Contact: _____ Phone #: _____ Relationship: _____
(Circle One) Home Work Cell

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(Circle One) Home Work Cell

How did you hear about us? (Circle One) Employee Hospital Insurance Internet Patient Referral Advertisement NFM NMC employee NOH employee Physician Referral Other: _____

Assignment and Release: I understand that I am financially responsible for charges incurred for services rendered. Full payment is expected at the time services are rendered. As a courtesy to you, we will submit your medical claim to your insurance company. I hereby authorize, and assign direct payment of my medical insurance benefits to Midwest Regional Health Services, LLC. I also authorize my medical provider to release my information requested by my medical insurance company.

_____ _____
Signature of Patient or Legal Guardian Relationship to patient

_____ _____
Patient's Name Date