



**Midwest Health Partners, P.C.**  
**FAMILY MEDICINE & CONVENIENT CLINIC**  
 1410 North 13<sup>th</sup> St Norfolk, NE 68701 402-371-0123

**If you do not have proof of insurance, you will be required to pay in full today. If you do have insurance, your co-pay or a minimum of today's service (20%) will be due. We will submit your claim to your insurance company.**

DATE: \_\_\_\_\_

**PATIENT INFORMATION**    **MARITAL STATUS:**    **SINGLE**    **MARRIED**    **DIVORCED**    **WIDOWED**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ PREVIOUS/MAIDEN: \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ POB: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: Month \_\_\_\_ Day \_\_\_\_ Year \_\_\_\_ AGE: \_\_\_\_\_ MALE FEMALE

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE #: (\_\_\_\_\_) \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT/PARENT INFORMATION (Policyholder)**    **MOTHER**    **FATHER**    **STEP PARENT**    **GUARDIAN**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ POB: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: Month \_\_\_\_ Day \_\_\_\_ Year \_\_\_\_ MALE FEMALE

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE #: (\_\_\_\_\_) \_\_\_\_\_

**SPOUSE/PARENT INFORMATION**    **MOTHER**    **FATHER**    **STEP PARENT**    **GUARDIAN**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ POB: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DOB: Month \_\_\_\_ Day \_\_\_\_ Year \_\_\_\_ MALE FEMALE

EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE #: (\_\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

RELATIVE'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE #: (\_\_\_\_\_) \_\_\_\_\_

FRIEND'S NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_\_) \_\_\_\_\_