



Midwest Health Partners, P.C.
FAMILY MEDICINE & CONVENIENT CLINIC

1410 North 13th 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 #: (_____) _____