Infectious Disease & Epidemiology Associates, PC
17030 Lakeside Hills Plaza, Suite 202 Omaha, NE 68130
Phone: 402-758-5240 Fax: 402-758-5792

DATE_____

REASON FOR SEEING DOCTOR_____**Date of injury/illness**_____

State in which injury occurred_____ **Was injury work related? YES NO**

PATIENT LEGAL NAME_____ Race/Ethnicity_____
(LAST) (FIRST) (MIDDLE)

Address_____City_____State_____Zip_____

Primary Phone _____ **Preferred Contact**

Cell Phone_____**Preferred Contact**

Work Phone_____**Preferred Contact**

SS#_____Age_____ Birth Date_____Sex _____M_____F Email address _____

Student Status ( ) Full time ( ) Part time School _____

Employer_____**Phone** (_____) _____

S M D W If Married: Spouse's Name _____

Spouse's Employer_____ Phone (_____) _____

If Minor or Student (covered under parents insurance)
Mother_____ Employer_____ Phone (_____) _____

Father_____ Employer_____ Phone (_____) _____

Emergency Contact _____ **Phone** (_____) _____

Referred by Self / Family / Friend / Physician (please circle)

Referring Physician _____Address _____

Family Physician _____Address _____

I authorize you to send clinic records to the above physicians Yes / No **Please sign** _____

BILLING INFORMATION

Primary Ins. Co._____ Policy # _____ Group # _____

Policyholder _____ SS# _____Birth Date _____ Sex ( )M ( )F

Secondary Ins. Co. _____ Policy # _____ Group # _____

Policyholder _____ SS# _____ Birth Date _____ Sex ( )M ( )F

Responsible Party _____

Address _____ City _____ State _____ Zip _____

Assignment and Release: I hereby assign my insurance benefits to be paid directly to IDEAS. I also authorize the physician to release any information requested by my insurance company. I understand I am financially responsible for all charges not covered by this assignment.

Signature_____ Date _____