Patient Registration Form
(Please fill in all fields completely)

Patient Information

Patient's full name	Date of Birth	Sex	Preferred name
Street address	City	State	Zip code

Telephone communication

***Home phone # (or cell if that is your primary phone)** _____

☐ I give Omaha Children's Clinic P.C. permission to leave relevant, detailed telephone messages regarding my care and **follow up, including test results**, on my answering machine when I am not available.

☐ I do **NOT** give Omaha Children's Clinic P.C. permission to leave detailed telephone messages regarding my care when I am unavailable. I will return the phone call.

***Cell phone #** _____

☐ I give Omaha Children's Clinic P.C. permission to **text** me **appointment reminders** regarding my upcoming appointments to the cell # shown above.

☐ I do **NOT** give Omaha Children's Clinic P.C. permission to text me appointment reminders. I prefer to be contacted by telephone.

Emergency Contact Information

Full name	Relationship to patient	Home #	Cell #

Guarantor Information (person financially responsible to pay your medical bills)

Full name	Relationship to patient	Date of birth
Full address	Home #	Cell #

Insurance Information

Insurance Company Name	Claims address	Phone #
Subscriber ID	Group #	Patient relationship to subscriber
Subscribers Name and Address	Subscribers DOB	

Notice of Privacy Practices Receipt of Acknowledgement and Consent for Treatment

My signature acknowledges I have been offered/received a copy of Omaha Children's Clinic P.C.'s HIPAA Privacy Practices for my review.

My signature also confirms I consent to medical care for myself at Omaha Children's Clinic, P.C., including all examinations, assessments, tests, therapy, outpatient diagnostic procedures including laboratory and radiology procedures, and other services and procedures that the physicians, other health care providers, and staff of this clinic deem necessary or appropriate. I understand the practice of medicine is not an exact science and no guarantees have been made to me regarding medical care.

_____ Date: _____

This form is valid until revoked by patient or patient reaches the age of 22

Omaha Childrens Clinic, P.C.

Delegation of Consent

Name of Patient: _____ DOB: _____

I hereby authorize the following individual(s) to consent to any and all medical care and attention deemed necessary and appropriate for me by a healthcare provider licensed in the state of Nebraska when I am unable to do so for myself. I also consent to clinic communications regarding my care with the individual(s) below. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent

Name: _____ Relationship to patient: _____

Name: _____Relationship to patient: _____

Name: _____Relationship to patient: _____

Name: _____Relationship to patient: _____

Patient signature: _____ Date: _____

Witness: _____ Date: _____