Barton G. Bellamy D.O.

WILLIAMSBURG FAMILY PHYSICIANS

Taylor Mowinkel, APRN-NP

Patient Demographic Information

***Please Print** *

Today's Date: _____

Last Name_____ First Name _____ MI _____ Sex **M / F**

Maiden Name _____ Preferred Name _____

Address _____ Apt # _____

City/State_____ Zip Code_____

Email Address _____

Primary Phone_____ **Cell Phone** **Home Phone**

Secondary Phone_____ **Cell Phone** **Home Phone**

Social Security Number_____-_____-_____ Marital Status: **M S W D**

Date of Birth _____/_____/_____ Student **N/A** **Full Time** **Part Time**

Employer _____

Business Phone _____EXT _____

Employer's Address _____

Emergency Contact

Name_____

Relationship to Patient _____

Address _____ ZIP Code_____

Primary Phone_____ **Cell Phone** **Home Phone**

Secondary Phone_____ **Cell Phone** **Home Phone**

How did you find out about us?

- ☐ **Social Media**
- ☐ **Website**
- ☐ **Employee Referral** _____
- ☐ **Word of Mouth/ Patient Referral** _____
- ☐ **Other**_____

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INSURANCE INFORMATION

Primary Insurance Name_____

Name of Policy Holder_____

Patient's Relationship to Policy Holder_____

Employer of Policy Holder_____

Secondary Insurance Name_____

Name of Policy Holder_____

Patients Relationship to Policy Holder_____

Employer of Policy Holder_____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim and I authorize payment of medical benefits to myself or the named provider for professional services rendered. I also assume responsibility to pay any amount that is not covered by my medical benefits coverage plan and that I assume all responsibility for all finance charges incurred on monthly forwarded unpaid balances:

Signed: _____ Date: _____

COMMUNICATION RELEASE

I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our services providers, now and in the future, may be used as a means to contact me, and in that this office and our services providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice. I also agree that this office or services providers and I consent to receive such test messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications. In the future, should I acquire a new or different cellular, land line or email address, I agree that this consent would stay effective.

Signed: _____ Date: _____

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MEDICAL HISTORY

Name: _____ DOB: _____

Preferred Pharmacy: _____

Allergies to Medicine _____

_____

Please Indicate your past medical history: _____

_____

_____

_____

_____

_____

Please list all current medications: _____

_____

_____

_____

_____

_____

Please indicate all your past hospitalizations and the reason: _____

_____

_____

_____

_____

_____

Please list all past surgeries: _____

_____

_____

_____

_____

_____

I acknowledge that the information on this application is true and correct to the best of my knowledge.

Signed: _____ Date: _____

6041 Village Drive, Suite 130 Lincoln, NE 68512 - Phone (402) 423-1382 - Fax (402)423-3390

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Williamsburg Family Physicians

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received, read, and understand a copy of the Williamsburg Family Physicians "Notice of Privacy Practices" on _____.
(Today's Date)

I understand that by signing this form, I am giving my consent to Williamsburg Family Physicians to use and disclose my protected health information to carry out treatment, payment activities, and health care operations.

Patient's Name: (Printed)

_____
First MI Last

Parent or Guardian: (Printed)

_____
First MI Last

Signature: _____ Date: _____

Relationship to Patient:

_____

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WILLIAMSBURG FAMILY PHYSICIANS

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CONSENT TO TREAT MINOR PATIENTS

(For Non- Emancipated Minors Less Than 19 Years Old)

Patient's Name: (Printed) _____
First MI Last

DOB: ____/____/____

By signing this form, I acknowledge that I am the Parent/ Legal Guardian of _____
Child's name

I agree to allow my child to receive medical care at Williamsburg Family Physicians. This consent applies to routine medical care including, but not limited to, physical exams, routine testing, office treatments, standard vaccinations, and any counseling related to the visit. I understand that NO MEDICAL INTERVENTIONS OR TREATMENT will be performed without attempts to discuss with a parent/ guardian first. I understand that exceptions to this would be the need for emergent/urgent medical care.

In my absence, I will allow the following individuals to act on my behalf to make appointments and give consent for any medical treatment my child may require:

Please Print Clearly the names of individuals authorized to consent on your behalf:

1. _____
2. _____
3. _____
4. _____

I consent to my child being seen by a provider at Williamsburg Family Physicians unaccompanied by a Parent/ Legal Guardian or above listed adult.

- ☐ Yes
- ☐ No

I UNDERSTAND THAT MY SIGNATURE EXPRESSES AN UNDERSTANDING OF THE CONFIDENTIALITY REQUIREMENTS LISTED ABOVE; I UNDERSTAND THAT THIS CONSENT IS VALID FOR 12 MONTHS, OR I REVOKE IT IN WRITING.

Parent or Guardian: (Printed) _____
First MI Last

Relationship to Patient: _____

Signature: _____ Date: _____