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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PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Williamsburg Family Physicians realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form below. Important Notes:

- Only one person may be designated on this form
- If you designate no one, Williamsburg Family Physicians will not release information to any family member or friend.

I authorize the person named below to: (check all that apply)

- ☐ Discuss my medical condition (includes **ALL** information inside my patient chart).
- ☐ Pick up any written prescriptions, medication samples or X-ray Films.
- ☐ Discuss billing and insurance, account balances, and make payments.
- ☐ Receive or discuss test results.
- ☐ All of the above

In accordance with the above, I hereby authorize Williamsburg Family Physicians to discuss with and release my medical information to the following individual:

Name: _____ DOB: _____/_____/_____

Relationship: _____ Phone: (_____) _____-_____

I hereby give permission to Williamsburg Family Physicians through its physicians and staff to release to my designee any information as noted above, about my medical condition or medical needs or the status of my confidentiality in connection with the release of this information.

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.

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

Patient's Signature: _____ Date: _____