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** **Word of Mouth** **Employee / Patient Referral**

Other _____

Barton G. Bellamy D.O.

WILLIAMSBURG FAMILY PHYSICIANS

Taylor Mowinkel, APRN-NP

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 RELASE

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: _____

MEDICAL HISTORY

Barton G. Bellamy D.O.

WILLIAMSBURG FAMILY PHYSICIANS

Taylor Mowinkel, APRN-NP

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