Vikrant Salaria, MD
Shelly Nanda, MD
Stephen Smith, MD
Margarita Rodriguez Escobar, MD
Internal Medicine, Family Practice

First Care Medical Center
PATIENT REGISTRATION FORM
(Please answer ALL questions)

800 Mercy Dr. Ste 120 | Council Bluffs, IA 51503
(712) 388-2770

3212 S. 24th St. Ste 101 | Omaha, NE 68108
(402) 916-4130

PATIENT INFORMATION

Last Name	First Name	M.I.	Birth Date	Age	Home No.	Cell No.

Present Street Address	Apt. #	City	State	Zip

Employment Status (Circle One) Employed Unemployed Disabled Retired	Occupation	Employer Name	Date Employed

Business No	Email	Marital Status (Circle one) S M W D SEP	How many Children	Social Security #

SPOUSE OR RESPONSIBLE PARTY INFORMATION (if different from the patient information)

Relationship to Patient	Last Name	First Name	M.I.	Home No.	Cell No.

Present Street Address	Apt. #	City	State	Zip

Business No	Date of birth	Social Security #

RESPONSIBLE PARTY INSURANCE INFORMATION

Do you have Insurance? Yes No	Insurance Carrier	Insurance Group (Circle One) PPO HMO Other_____	Subscriber ID

Insurance Company Address	City	State	Zip	Business No

EMERGENCY CONTACT (Alternate Contact Information)

Relationship to Patient	Last Name	First Name	M.I.	Home No.	Cell No.

Present Street Address	Apt. #	City	State	Zip

HOW DID YOU HEAR ABOUT US

NEWSPAPER	FRIEND	YELLOW PAGES	OTHERS

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize First Care Medical Center to furnish information to insurance carriers concerning my illness treatments and I hereby assign to the clinic all the payments for medical services rendered to my dependent myself. I understand that I am responsible for any amount not covered by insurance.

CONSENT TO TREATMENT

I (or the parent, legal guardian or authorize representative of the patient) authorize First Care Medical Center to provide reasonable and proper medical care.

SIGNATURE_____ VERIFIED BY _____ DATE _____