FAX TRANSMITTAL SHEET

To: Faith Regional Health Services **Fax #:** (402) 644-7649
Location: Registration **Date:**

From:

Confidentiality Warning

Attached pages within this transmission may include protected health information; under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat., section 68-313, if this information has been received in error, that recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

Pre-Registration

Thank you for choosing to pre-register with Faith Regional Health Services for your upcoming visit. Please read the following tips before continuing. They will answer many of your questions before you get started.

When to Register

Please complete the form below at least 7 business days prior to your scheduled procedure.
Once completed, you will be contacted by a member of our Guest Services staff within 48 hours to confirm

Previous Patients

You must complete the entire form even if you have previously been treated at Faith Regional. This allows us to view any changes that need to be made in your patient profile.

Questions

Please provide as much information as possible when completing this form. Any information not provided will be reviewed upon admission.

Privacy

We respect your privacy. The information you provide is confidential and will not be used for any other purposes or shared with a third party.

For your protection please be sure to include the first page of the fax transmission.
If you prefer to submit your information via US Mail, or if you have any questions call Registration at (402) 644-7589.

Patient Information

Patient's Name
Last Name _____ First Name _____
Middle Initial(s) ____ Suffix _____ Select One None Jr. Sr. II III IV V
Maiden Name _____

Contact Information

Mailing Address _____
Physical Address _____
City _____ State _____
Zip Code _____ County _____
Home Phone (+Area Code) _____
E-mail Address _____

Personal Information

Birth Date (mm/dd/yyyy) _____ Gender Male Female
Social Security Number _____
(888-88-8888)
Marital Status Select One Divorced Married Widowed Separated Single
Religious Preference
Race Select One Asian/Oriental African American/Black Hispanic Native American Middle Eastern White Other Unknown
Family Physician _____

Employment Information

Please select one of the following
- ☐ Minor Child
- ☐ Homemaker
- ☐ Disabled
- ☐ Retired - Date of Retirement
- ☐ Employed Outside the Home
- ☐ Self Employed

Occupation _____

Employment Status
- ☐ Part Time
- ☐ Full Time

Employer _____
Employer Address _____
City _____ State _____ Zip Code _____
Work Phone (+Area Code) _____

Guarantor

Guarantor's Name _____
Who is responsible for paying for these services?
Self ☐ If the patient is the responsible party, please check this box and move on to Emergency Contacts.

Last Name _____ First Name _____ Middle Initial(s) _____
Suffix ____ Select One None Jr. Sr. II III IV V
Maiden Name _____
Contact Information _____
Mailing Address _____
Physical Address _____
City _____ State _____ Zip Code _____
County _____ Home Phone _____
E-mail Address _____

Guarantor - Personal Information

Birth Date (mm/dd/yyyy) _____
Social Security Number _____
(888-88-8888)
Gender Select One Female Male
Marital Status Select One Divorced Married Widowed Separated Single
Religious Preference
Race Select One Asian/Oriental African American/Black Hispanic Native American Middle Eastern White Other Unknown

Please select one of the following
- ☐ Minor Child
- ☐ Homemaker
- ☐ Disabled
- ☐ Retired - Date of Retirement
- ☐ Employed Outside the Home
- ☐ Self Employed

Occupation _____

Employment Status
- ☐ Part Time
- ☐ Full Time

Employer _____
Employer Address _____
City _____ State _____ Zip Code _____
Work Phone _____
(+Area Code)

Emergency Contact #1

Contact's Name
Last Name _____ First Name _____
Maiden Name _____
Contact Information
Mailing Address _____ City _____
State _____ Zip Code _____ County _____
Home Phone _____
(+Area Code)

Personal Information
Birth Date (mm/dd/yyyy) _____
Social Security Number _____ Gender Select One Female Male
(888-88-8888)
Marital Status Select One Divorced Married Widowed Separated Single

Employment
Employer _____
Employer Address _____
City _____ State _____ Zip Code _____
Work Phone _____
(+Area Code)

Emergency Contact #2

Contact's Name
Last Name _____ First Name _____
Maiden Name _____
Contact Information
Mailing Address _____ City _____

State _____ Zip Code _____ County _____
Home Phone _____
(+Area Code)

Personal Information
Birth Date (mm/dd/yyyy) _____
Social Security Number _____ Gender Select One Female Male
(888-88-8888)
Marital Status Select One Divorced Married Widowed Separated Single

Employment
Employer _____
Employer Address _____
City _____ State _____ Zip Code _____
Work Phone _____
(+Area Code)

Procedure Information

Date of Procedure (mm/dd/yyyy) _____
Ordering Physician _____

Accident Information
Is this visit the result of an accident? Yes
No

Type of Accident
Select One
- ☐ Motor Vehicle Accident
- ☐ Crime
- ☐ Liability
- ☐ Workers Comp
- ☐ Personal Injury

Date of Accident _____
Time of Accident _____

Location _____
(include city & state)

Please briefly describe the accident. (Who, What, When, Where, Why) _____

Were the police notified?
- ☐ Yes
- ☐ No

If this was a motor vehicle accident, how were you involved in the accident? _____

Select One
- ☐ Driver
- ☐ Passenger
- ☐ Other

Insurance _____ Claim Number _____

Primary Insurance _____
Insured's Name _____

Insurance Company
Company Address _____
City _____ State _____ Zip _____
Insurance Agent _____ Policy Number _____
Group Number _____

Secondary Insurance _____
Insured's Name _____
Insurance Company
Company Address _____
City _____ State _____ Zip _____
Insurance Agent _____ Policy Number _____
Group Number _____

Medicare ☐ Yes Medicare ID# _____
Is the patient ☐ No
covered by
Medicare?

If yes, coverage is due to which of the following:
Select One ☐ Age
☐ Disability
☐ End Stage Renal Disease

Is the patient receiving benefits from any of the following?
☐ Black Lung Program
☐ Veterans Administration
☐ Research Grant

Medicaid
Is the patient ☐ Yes
covered by ☐ No
Medicaid?

Customer ID#
We will contact you by phone within 48 hours to confirm your registration. When is the best time to reach you?
Time ☐ 8 AM to 12 Noon
☐ 12 Noon to 4 PM
☐ 4 PM to 9 PM
Phone Number _____ Select One Home Phone Work Phone