Health Screening Questions

Name: ______________________ Date: ______________

Are you experiencing the following Symptoms?		
YES	NO	
		Shortness of breath or difficulty breathing
		New loss of taste or smell
		Muscle pain
		Sore throat
		Cough
		Chills
		Fever
		Have you been in contact with someone known or presumed to have COVID-19 within the past 14 days?

If you are experiencing any of these symptoms please put a mask on and if you do not have one we will provide one for you.

Patient Name ______________________ **DATE** ______________________

Reason for Visit:

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For Office Use ONLY:

Type of Visit		Vitals		Time	
Testing	Flu A/B Strep Covid Mono BS Chol FLU A/B-COVID combo	BP		Temp	
Procedure	Suture Wound Care Injection	HR		Ht	
Diagnostic	Extra BP EKG UltraSound	Sats		Wt	

Patient Registration Form

227 Main Street
PO Box 69
Louisville, NE 68037
(402) 234-5049
(402) 234-2797 (fax)

Patient Information:

☐ No changes

Name:______________________________

Date of Birth:__________ SS#:__________

Preferred Language:____________________

Race:__________ Ethnicity:__________

Physical Address:______________________

City:____________ State:____ Zip:______

Phone:______________________________

Email:______________________________

Mailing Address (if different from above):

Mailing Address:______________________

City:____________ State:____ Zip:______

Phone:______________________________

Email:______________________________

Best way to be contacted:________________

Can we leave a message: Yes No

Pharmacy:

Pharmacy Name:________________________

Address:______________________________

City:____________ State:____ Zip:______

Phone:______________________________

Emergency Contact Information:

Name:______________________________

Relationship:__________________________

Address:______________________________

City:____________ State:____ Zip:______

Phone:______________________________

Any known allergies, medical conditions, past surgeries

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Note of Privacy Practices:

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

____

Signature **Date**

Consent for Treatment:

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

____

Signature **Date**

Financial Responsibility:

Name:______________________________ Relationship to Patient:____________________

Date of Birth:________________________ Phone:____________________________

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that insurance will not be billed. In the event that my account is turned over to a collections agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs, if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in charges from my phone or device carrier, to me, for talk time, SMS messaging/texts or data usage for emails and voicemails. I also understand methods of contact may include pre-recorded/artificial voice messages and/or the use of automatic dial devices as applicable.

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Signature **Date**