LifeArts Integrated Health Center, PC / LifeArts Medical, LLC
306 N 7th St, Plattsmouth, NE 68048 ph: 402-296-2196 fax: 402-296-2197

# Patient Demographics

**** all information is necessary for proper documentation and billing purposes ****

**Last Name**:_____ **First Name**: _____ **Middle Initial**: _____

**Preferred Name**: _____ **Date of birth**: _____

**Marital Status**: ____ Divorced ____ Married ____ Single ____Widowed **Gender**: ____ Male ____ Female

**Home Phone**:_____ **Cell Phone**:_____ **Work Phone**:_____

**Address**: _____**City**: _____**State**: _____**Zip**: _____

**Email**: _____ **SSN**: _____

**Preferred Language**: _____ **May leave message on**: ☐Home Phone ☐Cell ☐NONE

**Race**: ____ Asian ____ Black ____ Pacific Islander ____ White ____ Other: _____

**Ethnicity**: _____ Hispanic ____ Non-Hispanic ____ Other: _____

**Emergency Contact Name**: _____ **Relationship**: _____

**Phone**: _____

**Employer**: _____ **Occupation:** _____

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Phone**: _____

**Primary Insurance**: _____ **Insurance ID #**: _____

**Policy Holder Name**: _____ **Relationship**: _____

**Secondary Insurance**: _____ **Insurance ID #**: _____

**Policy Holder Name**: _____ **Relationship**: _____

If you are here for a worker's compensation claim or automobile accident, we must have the information for the claim as well as billing information prior to initiating care. If it is not available you will be expected to pay for services at the time of the visit.

**I certify that the above information is true and correct to the best of my knowledge.**

**Patient signature**: _____ **Date signed:** _____

How did you hear about our clinic? ____ Friend ____ Family ____ Web Search ____ Phone Book ____ Other: _____