Dr. Torrey Rassfeld & Dr. Sylvia Trotter
2627 Stockwell St.
Lincoln, NE 68502

______________________________________ ______________ ________________
Patient's Last Name First MI Marital status Spouse's name

____ ________________
Mailing/ Billing Address City, State, Zip Home phone #

____ ________________
Physical Address City, State, Zip Cell phone #

___________________________________ ________________
Emergency Contact Name / Phone Number Relation to patient

Race: ☐White ☐Black or African American ☐Hispanic ☐Asian ☐Other________________________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown Primary Language _____________________

M F ___________ ______ ___________________________ ____
Gender Date of Birth Age Occupation Parent(s)/guardian name(s) if minor

Email address: ____ I would like appointment reminders via email ☐ **Yes** ☐ **No**
* Required for patient portal access to electronic health record

How did you hear about our clinic? ☐Friend/Family ☐Internet ☐Facebook ☐Insurance ☐Phonebook ☐Shoe store
☐Drive by ☐Former patient ☐Dr________________________ ☐Other____

Primary Physician: ____ Date last seen by your doctor____________________

Pharmacy name and location:____

_______________________________________ ____ _____________________
Patient's employer (or father's info if patient is minor) Business address Work phone #

_______________________________________ ____ _____________________
Spouse's employer (or mother's info if patient is minor) Business address Work phone #

Medical Insurance

Primary:_____________________________ ____ _____________________
Name of insurance company Insured's name, address Insured's birth date & SS#

Secondary:_____________________________ ____ _____________________
Name of insurance company Insured's name, address Insured's birth date & SS#

Tertiary:_____________________________ ____ _____________________
Name of insurance company Insured's name, address Insured's birth date & SS#

I have had an opportunity to read the practice financial policy and receive a copy if so desired.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ______________________
Patient or Guardian Signature **Date**