

EAR SPECIALISTS OF OMAHA PATIENT REGISTRATION FORM

Today's date:		Last name:		First:		Middle:	
Social security #:		Birth date: / /		Age:		Sex: <input type="checkbox"/> F <input type="checkbox"/> M	
Status: Single / Married / Divorced / Separated / Widowed / Student				E-mail address:			
Street address:							
City:				State:		ZIP Code:	
Home phone: () Please include area code		Cell phone: () Please include area code		Work phone: () Please include area code			
Patient's employer:				Occupation:			
Employer's Address:				City:		State:	ZIP:
Spouse's Name:		Birth date: / /		Spouse's social security #:			
Spouse's employer:		Spouse's business phone: () Please include area code		Occupation:			
Referring physician name:		Primary care physician:		If you were not referred by a physician, how did you hear about us? Family / Yellow Pages / Internet / Patient / Other			
Is this a work related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of injury:		Employer's name:			
INSURANCE INFORMATION (Please give your insurance card to the receptionist.)							
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please provide Primary insurance information		Insurance company name:					
Subscriber's name:		Social security number:			Birth date: / /		
Group #:		Policy #:		Co-payment \$			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain)							
Please provide Secondary insurance information		Insurance company name:					
Subscriber's name:		Social security number:			Birth date: / /		
Group #:		Policy #:		Co-payment \$			
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain)							
RESPONSIBLE PARTY (If patient is under 18)							
Name:		Social security number:			Relationship to patient:		
Address:	Street:	City:		State:	ZIP:		Home phone: ()
Father's name:	Birth date:	Social security #:	Employer:	Address:		Work phone: ()	
Mother's name:	Birth date:	Social security #:	Employer:	Address:		Work phone: ()	
IN CASE OF EMERGENCY							
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Britt A. Thedinger, MD, P.C. or insurance company to release any information required to process my claims.							
Patient/Responsible party signature _____				Print name _____		Date _____	