EAR SPECIALISTS OF OMAHA PATIENT REGISTRATION FORM

Today's date:	Last name:	First:	Middle:
Social security #:	Birth date: / /	Age:	Sex: ☐ F ☐ 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? ☐ Yes ☐ No	Date of injury:	Employer's name:

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ☐ Yes ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ 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_________