FAMILY EAR, NOSE AND THROAT CLINIC, P.C. ent

Paul S. Sherrerd, M.D.
Ruth Farrington, Au.D., CCC-A

6751 North 72nd Street, Suite 207
Omaha, NE 68122

Ph: (402) 572-3165
Fax: (402) 572-3170
www.familyentpc.com

NAME _____ _____ _____ SEX M F
LAST MI FIRST

Race/Ethnicity _____ Preferred Language _____ Birth Date ___/___/___

ADDRESS _____
Street name or PO Box City State Zip Code

SS# ___/___/___

Phone #1 (Home) _____ Employer _____

Phone #2 (Cell) _____ Address _____

Phone #3 (Work) _____ Email address _____

SPOUSE NAME _____ Birth Date ___/___/___ SS# ___/___/___

Spouse's employer _____ Spouse's phone number _____

PARENT NAME #1 (IF MINOR) _____ Birth Date ___/___/___

Parent's employer _____ SS# ___/___/___

PARENT NAME #2 (IF MINOR) _____ Birth Date ___/___/___

Parent's employer _____ SS# ___/___/___

PERSON RESPONSIBLE FOR BILL _____ Birth Date ___/___/___

Relationship to patient _____ SS# ___/___/___

PRIMARY INSURANCE COMPANY _____

Employer _____ Policy ID # _____

PERSON WHO CARRIES SECONDARY INS. (if any) _____ Birth Date ___/___/___

SECONDARY INSURANCE COMPANY _____ Policy ID # _____

FAMILY DOCTOR _____ REFERRING DOCTOR _____

Pharmacy _____ Pharmacy Address _____

DO WE HAVE PERMISSION TO

Leave a message on your answering machine at home with results? YES NO

Leave a message at your place of employment? YES NO

IS THERE ANYONE WITH WHOM WE MAY DISCUSS YOUR HEALTH INFORMATION? YES NO

If yes, whom and relationship _____

AUTHORIZATION TO RELEASE INFORMATION AND INSURANCE ASSIGNMENT

I authorize payment directly to the above-named physician(s) of any insurance benefits affording coverage to the named patient but not to exceed the physician's regular fees for such services. I understand that I am financially responsible for all charges. I also authorize the release of such information as may be necessary to the proper authorities.

_____ _____
Signature of patient or parent if minor Date