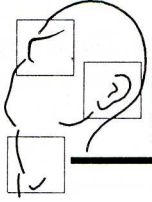

Ear, Nose & Throat Specialists of Abilene

1233 N. 18th Street • Abilene, Texas 79601 • (325) 437-3687 • FAX (325) 437-3873

Jeffrey M. Braaten, D.O. • Gary D. Goodnight, D.O. • Taylor R. Tidmore, M.D. • Paula Parkhill, FNP-BC

PLEASE PRINT ALL INFORMATION

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

PATIENT'S NAME: _____ D.O.B.: _____ AGE: _____ SEX: _____

SOCIAL SECURITY #: _____

NAME OF PARENT OR GUARDIAN (IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE): _____

NAME OF PERSON(S) RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM PATIENT): _____

MAILING ADDRESS: _____ APT.: _____

CITY, STATE, ZIP: _____ HOME PHONE: (_____) _____

BUSINESS PHONE: (_____) _____ EMPLOYER: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE PARENT / SPOUSE: (_____) _____ EMPLOYER: _____

BUSINESS ADDRESS: _____

FINANCIALLY RESPONSIBLE PERSON(S):

DRIVER'S LICENSE #: _____ STATE: _____ WE WILL ASK TO MAKE A COPY OF YOUR LICENSE

PRIMARY INSURANCE: _____ 2ND INS. _____

NAME OF INSURED: _____ D.O.B.: _____ S.S.#: _____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME? ❒ YES ❒ NO

MAY WE LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? ❒ YES ❒ NO

PLEASE LIST PERSONS WITH WHOM WE CAN DISCUSS YOUR MEDICAL INFORMATION:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: (_____) _____ BUSINESS PHONE: (_____) _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____

OTHER PHYSICIANS TREATING YOU: _____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO REFERRING DOCTOR AND/OR ANY DOCTOR TO WHOM DRS. BRAATEN , TIDMORE, OR GOODNIGHT MAY REFER ME. I AUTHORIZE MY FAMILY OR REFERRING DOCTOR TO RELEASE MY RECORDS TO DRS. BRAATEN, TIDMORE, OR GOODNIGHT. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND REQUEST PAYMENTS OF INSURANCE BENEFITS BE MADE TO **ENT SPECIALISTS OF ABILENE**. I HEREBY AFFIRM THAT ALL INFORMATION PROVIDED BY ME IS TRUE TO THE BEST OF MY KNOWLEDGE, AND WILL ACCEPT FINANCIAL RESPONSIBILITY FOR MY ACCOUNT WITH **ENT SPECIALISTS OF ABILENE**.

AUTHORIZED SIGNATURE: _____ S.S. #: _____ D.O.B.: _____

RELATIONSHIP TO PATIENT: _____