Butler County
Health Care Center
402-367-1200 • www.bchccnet.org
372 South 9th Street • David City, NE 68632

COLUMBUS OTOLARYNGOLOGY CLINIC

Nila M. Novotny, M.D. – James M. Weekly, M.D. – Paul S. Sherrerd, M.D. – Amber Citta, APRN – Jennifer Swantek, APRN
4508 38th St., Suite 152 · Columbus, NE 68601

Name of Patient _____ Other Name(s) _____
LAST FIRST MI MAIDEN/OTHER
Patient Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Birth Date ___/___/___ SEX ____M ____F SSN _____-_____-_____ Marital Status (circle one) S M D W
Race _____ Family Physician _____ Referring Physician _____
Retired: Yes / No Disabled: Yes / No Employer _____ Occupation: _____
Email address _____ (Authorization for patient portal access Yes / No)
Preferred Method of Contact ____Home Phone ____Cell Phone ____Work Phone ____Email ____US Mail

Spouse/Guardian Name _____ Date of Birth ____/____/____
Address if different than patients _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email address _____ SSN _____-_____-_____
Retired ____ Employer _____ Occupation _____

DO YOU HAVE MEDICAL INSURANCE? _____YES _____NO If you have insurance, we will make a copy of your card(s).
Person Financially Responsible (If not Patient) _____
Relationship to Patient _____ Date of Birth _____ Phone Number _____
Address _____ City _____ State ____ Zip _____
**If you would like to authorize us to discuss your account information with anyone other than yourself, please list those persons below. This list would include spouse, children, siblings and friends.

NAME: **RELATIONSHIP:** **PHONE NUMBER(s):**

_____
_____

EMERGENCY CONTACT (RELATIVE, FRIEND, NEIGHBOR)
Name _____ Relationship to Patient _____
Phone Number _____ Address _____

HIPAA CONTACT INFORMATION
_____ (initial) COLUMBUS OTOLARYNGOLOGY CLINIC is permitted to share any and all medical information with the following individuals listed below, including test results, sensitive information as stipulated by the State of Nebraska and information disclosed during hospital and/or office visits. With no exceptions to information shared.
With these exceptions: _____
Persons authorized to receive my medical information: (Include: Full name, relationship, and phone number.)

NAME: **RELATIONSHIP:** **PHONE NUMBER(s):**

_____
_____

SIGNATURE _____ **Date** _____

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