

COLUMBUS OTOLARYNGOLOGY CLINIC

4508 38TH STREET, SUITE #152
COLUMBUS, NE 68601-1668

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Ear, Nose and Throat
Head and Neck Surgery
Facial Plastic Surgery

FAX TRANSMISSION COVER SHEET

DATE: _____

FAX #: (____) _____

TO: _____

NUMBER OF SHEETS: _____

ATTN: _____

PATIENT REGISTRATION CHECKLIST

1. Complete and sign the Minor Child Registration Form
2. Complete both pages (1 & 2) of Patient History Form
3. Complete and sign Patient Consent/Acknowledgement Form
4. Print out HIPAA - Notice of Patient Privacy
5. Please gather any health insurance cards or other insurance information and bring them with you to the appointment
6. The completed forms can be:
 - a. Brought in at the time of the appointment, or
 - b. Faxed to 402-563-3520, or
 - c. Mailed to:

Columbus Otolaryngology Clinic
4508 38th St., Suite #152
Columbus, NE 68601-1668

SINCERELY,

(Please sign your name below)

BY: _____

NOTICE

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