

METRO ENT & FACIAL PLASTIC SURGERY
a division of Centers for Advanced ENT Care, LLC
Annette M. Pham, M.D.

PLEASE PRINT CLEARLY

■ Patient Information

Today's Date: _____

Name (Last, First, Middle) _____

Sex: M F

Birth Date _____ Occupation _____

Home Phone _____

Email address _____

Cell Phone _____

Address _____

Work Phone _____

City _____ State _____ Zip _____

Check if Minor (less than 18) Marital Status: Single Married Partner Divorced Widowed Separated

Emergency Contact _____ Relationship _____ Phone _____

Who Referred You to Our Office? _____ If this is your Primary Care Physician, please
give address: _____ Phone _____

If not, your Primary Care Physician is _____ Address _____

Have you seen an ENT in the past 3 years? _____ If so, who? _____

Preferred Pharmacy Name _____ City & State _____

■ Primary Insurance

Insurance Company _____

Insurance ID # _____ Group # _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Birth Date _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company _____

Insurance ID # _____ Group # _____

Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Birth Date _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

■ Assignment and Release

I hereby authorize payment directly to Metro ENT & Facial Plastic Surgery division of Centers for Advanced ENT Care of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits, to my insurance company, or to the Maryland Insurance Commissioner. In addition, I also authorize the use of this signature on all my insurance submissions. I also agree that a photocopy of this form may be used in lieu of the original. I have read and agreed to the above.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Print Name: _____

Date of birth: _____

RACE

- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Hispanic
- Other Race _____
- Refused to Report

LANGUAGE

- English
- Spanish
- Chinese
- Vietnamese
- Russian
- Other _____

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino
- Refused to Report