

**METRO ENT & FACIAL PLASTIC SURGERY**  
**a division of Centers for Advanced ENT Care, LLC**

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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