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 _____ **Soc. Sec. #** _____ **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 doctor 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 _____ Soc. Sec. # _____ **Birthdate** _____

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 _____ Soc. Sec. # _____ **Birthdate** _____

Address _____ **Home Phone** _____

Employer _____ **Work Phone** _____

■ Assignment and Release

I hereby authorize payment directly to Metro ENT & Facial Plastic Surgery 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 as necessary to obtain payment for my services. I authorize a copy of this document to be used in place 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