



LAWRENCE MARTIN MD, FACS

COSMETIC AND RECONSTRUCTIVE FACIAL PLASTIC SURGERY
ENT - HEAD AND NECK SURGERY

Diplomate of the American Board of Otolaryngology-Head & Neck Surgery
Diplomate of the American Board of Facial Plastic and Reconstructive Surgery

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Please Print

Referred By _____

Patient Name - Last _____ First _____ Middle Initial _____

Address _____

City _____ State ____ Zip _____

Home Phone _____ Work _____ Cell _____

Birthdate _____ Sex M F Patient's Social Security Number _____

Marital Status Single Married Separated Divorced Widowed Minor

Spouse Name _____ Spouse Birthday _____

If the patient is a college student, Full time Part time

Insurance Information

Primary Insurance _____ Group No. _____ ID No. _____

Subscriber's Name _____ Relationship to Patient _____

Address (if different) _____

City _____ State ____ Zip _____

Subscriber's Birthday _____ SSN _____ Work Phone _____ Cell _____

Secondary Insurance _____ Group No. _____ ID No. _____

Subscriber's Name _____ Relationship to Patient _____

IS THIS VISIT RELATED TO AN ACCIDENT? Y N DATE OF ACCIDENT _____ Please advise the front desk at this time.

If the patient is a minor, please provide the other parent's name, work and cell phone numbers

Name _____ Work Phone _____ Cell Phone _____

Person to notify in case of an emergency (other than listed above)

Name _____ Relationship _____ Phone _____

E-MAIL Address (to be used for notice of seminars, promotions, etc.)

_____ No, I decline

AUTHORIZATION AND RELEASE

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Lawrence Martin, MD.

_____ Date _____

Signature of patient (or parent if minor)