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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Today's date: _____

PLEASE PRINT

REFERRED BY: _____

Patient Name:

_____
Last First Middle Initial

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home Phone: _____ **Cell Phone:** _____

Birthdate: _____ **Sex:** _____ **Patient's SSN:** _____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Widowed ( ) Minor

Spouse's name: _____ **Spouse's B-day:** _____

If the patient is a college student, full-time _____ **part-time** _____

Patient Employer: _____ **Occupation:** _____

Address: _____ **Phone Number:** _____

Pharmacy name: _____ **Phone Number:** _____

INSURANCE INFORMATION:

Primary Insurance: _____ **Group:** _____ **ID #:** _____

Subscribers Name: _____ **Relationship to Patient:** _____

Address (if different): _____

City: _____ **State:** _____ **Zip code:** _____

Subscriber's B-day: _____ **SSN:** _____ **Work Phone:** _____ **Cell:** _____

Secondary Insurance: _____ **Group:** _____ **ID #:** _____

Subscribers Name: _____ **Relationship to Patient:** _____

IS THIS VISIT RELATED TO AN ACCIDENT? _____ **DATE OF ACCIDENT?** _____

Please advise this at the front desk at this time.

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

Name: _____ **Work:** _____ **Cell:** _____

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

_____ **No, I Decline:** _____

AUTHORIZATION & RELEASE

I authorize 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 herby authorized payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____

Signature of patient (or parent if minor) **Date**