Jeffrey Marcus, M.D., FACS

Ear, Nose & Throat • Facial Plastic Surgery • Allergy
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PATIENT INFORMATION

Patient's Name ______________________________ Home phone____________

Address ______________________________ Work phone____________

City ____________State _______ ZIP code__________ Cell phone ____________

Date of Birth __________ Age______ Sex_____ Social Security No______________

Employer______________________ Occupation ______________________

Spouse's Name______________________ Spouse's Employer______________________

Parent or legal guardian (IF patient is under 18)

Address (IF different from above) ______________________________

Date of birth______________________ Social Security number______________________

Occupation ______________________ Employer ______________________

Work phone ______________________ Work address______________________

Referred by ______________________

Nearest relative, neighbor, or friend NOT living with you (In case you cannot be reached):

Name______________________________ Phone ____________

Address ______________________________

Patient's Medicare No.______________ Secondary Insurance______________________

Patient's Primary Insurance (if not Medicare) ______________________________

Policy Holder SS# ______________ Policy Holder Date of Birth______________________

SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Provider listed or xerox copies from my insurance cards and attached for any services furnished me by the listed provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA-1 500 form, or elsewhere on other approved claim forms or electronically submitted claims, assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. My signature also authorized Dr. Marcus to release any information regarding my medical condition to my referring physician, should there be one. I understand that I may receive copies of my office notes at the same cost charged by the Citrus County Courthouse for copies made there.

I certify that I am NOT INSURED BY CHAMPUS OR ANY HMO.

Patient Signature ______________________________ Date______________