Jeffrey Marcus, M.D., FACS

Ear, Nose & Throat • Facial Plastic Surgery • Allergy

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PATIENT INFORMATION – Please **CIRCLE** choices or **FILL IN** the blanks.

Patient Name: _____
First **Middle** **Last**

Salutation
Mr. Ms. Mrs. Dr. Rev. Fr.

Date of Birth: ____/____/_____ **Sex:** M F **SSN:** _____

Marital Status
Single Married Other

Patient Address: _____

Pharmacy and Location

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

_____

Email: _____

Order of Preference
(1,2 or 3)

Patient Phone: Home _____

Cell _____ Work ___ Home ___ Cell ___

Work _____

Language Preference: _____

Race: ☐ Caucasian ☐ African American ☐ Asian

Ethnicity: ☐ Non Hispanic/Latino ☐ Hispanic/Latino

Employer: _____ **Occupation:** _____

Spouse's Name: _____ **Employer:** _____

Parent or legal guardian (IF patient is under 18) _____

Date of Birth: _____ **SSN:** _____ **Employer:** _____

Work Phone: _____ **Work Address:** _____

Referred by _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Patient's Primary Ins # _____ **Secondary Ins #** _____

Policy Holder SSN: _____ **Policy Holder DOB:** _____

I authorize the Physician or Physician Assistant treating/examining me to release any medical information necessary for payment or continuation of care or to any physician to ensure continuity of medical care. My signature below also authorizes payment directly from the insurance company to the provider. I certify that the information regarding my insurance is correct and that any holder of medical or other information may release the information necessary to process an insurance claim. The physician accepts the Medicare allowable as the full charge for Medicare patients, with the patient being responsible for any deductible, co-pay or non-covered service.
I understand that I may receive copies of my office notes at the same cost charged for copies at the Citrus County Courthouse.

I certify that I am NOT insured BY TRICARE PRIME (needs authorization) or HMO plan

Patient/Guardian Signature:_____ Date:_____