Name:_____ Date of Birth: ___/___/___ Age _____ Sex: M F

Home #:_____ Work #:_____ Cell #:_____ Email Address:_____

Address:_____ City:_____ State:_____ Zip:_____

SS#:_____—____—_____ Marital Status: M D S W Sep.

Reason for Consultation:_____ **Date of Injury** (if applicable)_____/_____/_____

Have you consulted other Doctors about this? Yes(recently)____ Yes(a while ago)____ No____

How did you **first** hear about our office? Word of Mouth/Patient Referral _____ Name (if known) _____

Baltimore Mag Top Doctors _____ Physician Referral _____ Internet Search ____ Other _____

Occupation:_____ Employer:_____

Spouse's Name:_____ Spouse's Occupation:_____

Spouse's Employer:_____ Spouse's Work #:_____

Emergency Contact:_____ Relationship:_____ Home #:_____ Work:_____

I do____ I do not____ have Advance Directives. **(It is your responsibility to provide a copy of your advance directive to the Surgery Center prior to procedure.)**

Family Doctor:_____ Phone #:_____ Pharmacy #:_____

Name of Primary Insurance Company_____ Effective Date:_____

Primary Insurance ID #:_____ Group #::_____

Subscriber Name:_____ Relationship:_____

SS #:_____-____-_____ Date of Birth:____/____/____ Employer:_____

Referral required? Yes____ No____ Referring Physician:_____

Name of Secondary Insurance Company_____ Effective Date:_____

Secondary Insurance ID #:_____ Group #::_____

Subscriber Name:_____ Relationship:_____

SS #:_____-____-_____ Date of Birth:____/____/____ Employer:_____

Insurance Address (if not on card):_____

Participating labs for specimens/testing:_____

Release of Information

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical information to my insurance carrier, Medicare, and or Medical Service of Maryland.

Assignment of Benefits

I request the payment of benefits (Medicare, or other insurance carriers) be made directly to The Plastic Surgery Center of Maryland, P.A. and/or Surgical Specialty Suites, Inc. for services rendered to me by Adam L. Basner, M.D., Lawrence I. Rosenberg, M.D. and/or Michele A. Shermak , M.D. I authorize Adam L. Basner, M.D., Lawrence I. Rosenberg, M.D., and/or Michele A. Shermak, M.D. to apply for benefits on my behalf.

_____

Signature Date

OVER TO COMPLETE FORM