



BALTIMORE CENTER FOR
FACIAL PLASTIC SURGERY

PATIENT INFORMATION

Name _____ DOB _____ SS# _____
Address _____
City _____ State _____ Zip _____
Phone (h) _____ (w) _____ (m) _____
E-mail Address _____
Emergency Contact _____ Ph # _____
Referring MD Name _____
Primary MD Name (if different) _____

HEALTH INSURANCE INFORMATION

Primary Policy Holder _____
Relationship to patient _____
Insurance Co. _____
Policy# _____ Group# _____
SS# _____ DOB _____ Effective Date _____

Secondary Policy Holder _____
Relationship to patient _____
Insurance Co. _____
Policy # _____ Group # _____
SS# _____ DOB _____ Effective Date _____

ASSIGNMENT OF BENEFITS

I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company(s) or coverage of services is denied, I will be directly responsible for all fees incurred with the Baltimore Center for Facial Plastic Surgery, LLC and/or Randolph B. Capone, MD. I authorize payment of medical benefits to the provider for all services rendered if the provider is a participating provider with my insurance. I also authorize the release of any medical or other information necessary for the processing of claims.

AUTHORIZED SIGNATURE _____ DATE _____