MARLOWE MD
& MARRS MD
ENT + AESTHETICS

Today's date:	Primary Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Preferred name:	Social Security Number:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Primary address:	City/State:	Zip Code:
Secondary address:	City/State:	Zip Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

COMMUNICATING WITH YOU

Please check all boxes that you give Marlowe & Marrs ENT permission to use for your communications:

Home Phone Number:	Cell Phone Number:
○ You may contact me by telephone ○ You may leave a voicemail	○ You may contact me by text message

E-mail: *This will give you access to your records through the portal

If you give permission for us to communicate with anyone else, please complete the list below:

Name:	Relationship:	○ Medical/ Health ○ Appointment ○ Billing
Name:	Relationship:	○ Medical/Health ○ Appointment ○ Billing

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Andrew Marlowe, MD, PA, Chad Marrs, MD or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*