ZEMAN SURGICAL SERVICES

CONFIDENTIAL PATIENT INFORMATION

Date_____ **Pharmacy** _____

Full Name: _____ **Age:**_____

Mailing Address: _____

Social Security #:_____ **Date of Birth:** _____ **Sex: M F**

Marital Status: M S D W **Home Phone:** _____ **Work Phone:** _____
Cell Phone:_____ **Email:** _____ **Employer:**_____

Current Medications: _____

_____

_____

Allergies to Medications/Latex: _____
Past Surgeries: _____

_____

_____

Primary Care Physician: _____

Emergency Contacts
Name: _____ **Phone Number:**_____ **Relationship:**_____
Name: _____ **Phone Number:**_____ **Relationship:**_____
May we leave a message and/or identify ourselves at the above contacts? Yes/No

ASSIGNMENT AND RELEASE

I, the undersigned, authorize Dr. Charles M. Zeman to act as my, or my dependent's agent and to releae any information, including the diagnosis and record of any treatment or examination rendered to me/my dependent during the period of such healthcare to my insurance companies, third party payors and/or health care practitioners. I authorize and request my insurance company to pay insurance benefits otherwise payable to me, directly to Dr. Charles M. Zeman. I understand that my health insurance carrier may pay less than the actual bill for services. I agree to be responsible for all insurance deductible, co-insurance, co-pay, non-covered services and/or other amounts due for services rendered on behalf of myself/my dependent. I authorize the use of this signature on all insurance submissions. Should the charges be referred to an attorney/agency for collection, the cause of action may be brought in the county in which the indebtedness incurred, and the undersigned shall pay reasonable attorney's fees and collection expense. A copy of this authorization may be used in place of the original. I am familiar and have received a copy of the privacy policies of Zeman Surgical Services.

Signature of insured/guardian/responsible party _____
Relationship: _____ Date: _____

MEDICARE PATIENTS ONLY

I, the undersigned, request that payment of authorized Medicare benefits be made to Dr. Charles M. Zeman on my behalf for any services furnished to me by him. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand that Dr. Zeman accepts Medicare assignment and I will be responsible for any Medicare deductible, co-insurance amount, or non-covered service amount.

Print Name: _____ Signature: _____
Date of Birth: _____ Medicare # : _____