ZEMAN SURGICAL CLINIC

CONFIDENTIAL PATIENT INFORMATION

Date________________________ Pharmacy____________________

Patient's full name ____ Age________
first mi last

Mailing address____
street # and/or p.o. box city state zip code

Social Security #___________________________ Date of birth_______________ Sex: **M** **F**

Marital status: **M** **S** **D** **W** Spouse (if applicable) ____________________________

Home phone________________ Work phone________________ Cell phone ________________

Employer________________________ Email: ________________________________

Please circle if you have membership in: Senior Circle, Healthy Women, Both or Neither

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Responsible party (IF MINOR) ________________________ Relationship to patient ________________

Mailing address____

Date of Birth________________ Social Security #________________ Sex: **M** **F** Marital Status: **M** **S** **D** **W**

Spouse (if applicable) ____________________ Employer______________________________

Work phone for responsible party and spouse (if applicable) ______________________________

Please list the names & phone numbers of three people we can call in case of an emergency, or the need to contact you:

1) ____ relationship______________

2) ____ relationship______________

3) ____ relationship______________

May we leave a message and/or identify ourselves at the above listed phone numbers? ________

ASSIGNMENT AND RELEASE

I, the undersigned, authorize Dr. Charles M. Zeman to act as my or my dependent's, agent and to release any information, including the diagnosis and records of any treatment or examination rendered to me or 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 or my dependent. I authorize the use of this signature on all insurance submissions. Should the charges be referred to an attorney or 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 (AUTHORIZATION)

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.

Name(please print)______________________________________ Date of birth________________

Signature____ Medicare#________________