Valley Vein and Vascular Surgeons
Sammy A. Zakhary, M.D., P.C.
Dana Garner, NP

Patient Information

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ ◯ Male ◯ Female

Address: _____ Apt/Unit #: _____

City, State, Zip: _____ ◯ Single ◯ Married ◯ Widowed

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Emergency Contact Name and Phone:

_____

Primary Care/Referring Physician Information:

Primary Care Physician:

_____

Who Referred You to Us?:

_____

Insurance Information

Primary Insurance Name:

_____

Subscriber ID: _____ Group #: _____

Secondary Insurance Name: _____

Subscriber ID: _____ Group #: _____

I hereby authorize payment directly to Sammy A. Zakhary, MD, PC for all surgical and/or medical insurance benefits, if any, for unpaid services rendered. I also authorize the release of any information necessary to process claims for said services. I authorize the release of records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physicians' participation with my health plan. I also agree to pay all charges and/or co-payments and deductibles at the time of service. This will also serve as an authorization for release of emergency department, urgent care, and/or medical records which may be necessary for my medical care.

Signature of Patient or Responsible Party: _____

Date Signed: _____