Sammy Zakhary M.D., P.C.
Valley Vein and Vascular Surgeons
6591 W Thunderbird Rd Suite D2
Glendale, Arizona 85306

PATIENT INFORMATION

Last Name:_____First Name:_____

Address: _____City, State, Zip:_____

Phone Number: Home_____Cell_____Work _____

Date of Birth:_____Gender: M F Social Security #:_____Marital Status: _ _

Email address: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician:_____Phone Number: _____

Street Address:_____City:_____State:_____Zip: _____

- I authorize the release of my medical record information to my Primary Care Physician

REFERRING PHYSICIAN

Referring Physician:_____Phone Number: _____

Street Address:_____City:_____State:_____Zip: _____

- I authorize the release of my medical record information to my Referring Care Physician

INSURANCE POLICY HOLDER INFORMATION

Insurance:_____Subscriber ID#:_____Group#:_____

Secondary

Insurance:_____Subscriber ID#:_____Group#:_____

* Emergency Contact:_____Phone #: _____

**Next of Kin:_____Phone #: _____

I hereby authorize payment directly to Sammy A Zakhary, M.D., P.C. for all surgical and/or medical insurance benefits, if any 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 physician's 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 medical care.

Signature of Patient or Patient Representative Date