

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
