Sammy Zakhary M.D., P.C.
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