SYED A. A. ZAIDI, MD, PLLC - PATIENT INFORMATION SHEET

PLEASE COMPLETE ALL INFORMATION – PLEASE PRINT

PATIENT INFORMATION

Last:_____First_____ Middle _____Suffix:_____

Previous Last Name:_____ Sex: Male Female Marital Status: S M D W

Date of Birth:_____ SSN:_____ Race:_____

Home Phone:_____ Cell Ph:_____ Other Phone:_____

Mailing Address:_____City:_____ ST:_____ Zip:_____

Employer:_____ Work #:_____ Advance Directives: _____ YES _____NO

EMAIL ADDRESS:_____

RESPONSIBLE PARTY INFORMATION (Who is Responsible for Bill)

( ) **SAME AS PATIENT OR RELATION TO PATIENT:**_____ Name:_____

Address:_____ City:_____ ST:_____ Zip:_____

Home Phone:_____Cell Ph:_____ Date of Birth:_____ Sex:_____

S.S. #:_____ Employer:_____ Work #:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

PHARMACY NAME:_____

PRIMARY INSURANCE PLEASE COMPLETE ALL INFORMATION

INSURANCE COMPANY:_____

ID #:_____ GROUP #:_____

Who Holds the Insurance:
Name (First, MI Last):_____

Date of Birth:_____ SSN:_____

( ) Same as Above or:
Policy Holder Address:_____

Phone #:_____ Relationship to Patient_____

SECONDARY INSURANCE PLEASE COMPLETE ALL INFORMATION

INSURANCE COMPANY:_____

ID #:_____ GROUP #:_____

Who Holds the Insurance:
Name (First, MI Last):_____

Date of Birth:_____ SSN:_____

( ) Same as Above or:
Policy Holder Address:_____

Phone #:_____ Relationship to Patient_____

I hereby authorize (a) Syed A. A. Zaidi MD PLLC, the clinic and it's physicians and employees to see and treat me as they deem medically necessary and appropriate for diagnosis and treatment. I understand that I have the right to ask questions and receive information regarding my care and have the right to withdraw in writing my consent to any treatment or tests. (b) that I will provide all current and valid insurance information at the time of each visit. If my Insurance should change at any time, I understand that I am responsible for providing Syed A. A. Zaidi, MD. PLLC with my updated insurance before I am treated. (c) payment of insurance benefits to be made directly to Syed A. A. Zaidi, MD, PLLC. I understand that I may be responsible for any and all amounts not paid by my insurance company. (d) If my account becomes delinquent, and legal action becomes necessary, I agree to pay all attorney and collection fees incurred (e) release of information, including protected health information to provide treatment, for health care services and to obtain payment for services incurred (f) Syed A. A. Zaidi, MD, PLLC to obtain records from other sources as may be deemed necessary in the diagnosis, treatment, or processing of my claim.

Signature:_____ **Date:**_____ **Relationship to Patient:**_____