**PATIENT DEMOGRAPHIC SHEET**
**ANNETTE M ZAHAROFF M.D. P.A.**

Appointment Date:_____
Scheduled By:_____

Date: _____

ACCOUNT #_____

PCP: _____

Whom may we thank for your referral?
Name_____
Address_____
City/State/Zip_____
Phone_____

**PERSONAL INFO**

| | | | |
|---|---|---|---|
| Mr./Mrs./Ms.: | | Sex: M F | Age:<br>Date of Birth: |
| Marital Status: | Social Security No.: | | Home Phone ( ) |
| Address: | | City/State/Zip: | |
| Occupation: | Employer: | | Work Phone ( ) |
| Employer's Address: | | City/State/Zip: | |
| Spouse or Parent's Name: | | Home or Business Phone ( ) | |
| Emergency Contact: | | Phone Number ( ) | |
| Email Address: | | | |

**MEDICAL INFO**

| | | | |
|---|---|---|---|
| Reason for your visit: | | | |
| Were you involved in an accident? Y N | Date of Injury | | Work Related Y N |
| What medications are you taking? | | | |
| Please state any medication allergies: | | | |
| Previous MD's seen for this condition: | | | |
| Previous Diagnostic Tests performed for this condition: | | Where? | |

**INSURANCE INFO**

**PLEASE PROVIDE INSURANCE OR MEDICAL CARD TO FRONT DESK**

| Primary Insurance Co. (Please indicate if Workers Comp) | Secondary Insurance Co. |
|---|---|
| Address: | Address: |
| City/State/Zip: | City/State/Zip: |
| Phone ( ) | Phone ( ) |
| I.D. or Claim No.: | I.D. or Claim No.: |
| Group No.: | Group No.: |
| (If Workers Comp.) Adjustor: | (If Workers Comp.) Adjustor: |
| Insured Name: | Insured Name: |
| Insured's Social Security No.: | Insured's Social Security No.: |
| Insured's Date of Birth: | Insured's Date of Birth: |
| Insured's Employer: | Insured's Employer: |

**RELEASE**: I, Hereby, authorize the release of any information acquired in the course of my examination and treatment to my insurance carriers. I permit a copy of this authorization to be used in place of the original.
Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.
**IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT EACH VISIT.**
I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Annette M. Zaharoff, M.D. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

SIGNED _____ DATE _____

**ALLERGIC TO:**

**Annette Zaharoff, M.D., P.A.**
**9631 Huebner**
**San Antonio, TX 78240**

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I give my consent for Annette M. Zaharoff, M.D., P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

I have read and understand the Notice of Privacy Practices. Annette M. Zaharoff, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Zaharoff's Office Manager.

With my consent, Annette M. Zaharoff, M.D., P.A. and/or office staff members may call my home or other alternative location and leave a message on voice mail, by fax, or in person in reference to items that assist the practice in carrying out treatment, payment and Healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, this practice may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Patient's Name

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Date

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Print Name of Patient or Legal Guardian