

PERSONAL INFORMATION

PATIENT NAME: _____ DOB _____ SS# ____ - ____ - ____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE _____ WORK PHONE _____

SEX: MALE _____ FEMALE _____ MARITAL STATUS _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE _____ WORK PHONE _____

OCCUPATION: _____ EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

HEALTH INSURANCE

PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD AND PHOTO IDENTIFICATION

PRIMARY COMPANY: _____ SECONDARY COMPANY: _____

ID # _____ GROUP # _____ ID # _____ GROUP # _____

OTHER INSURANCE: _____

GUARANTOR NAME (PERSON TO BILL IF OTHER THAN PATIENT) _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE _____ WORK PHONE _____

EXTENDED AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this or related Medicare or Insurance claim. I understand that I am financially responsible for services rendered regardless of my insurance status. I also understand that I am financially responsible for all and/or referring physicians when required. I permit a copy of this authorization to be used in place of the original. I FURTHER ACKNOWLEDGE THE OFFICE "NO SHOW" POLICY. IF I FAIL TO NOTIFY THE OFFICE WITHIN 24 HOURS BEFORE MY SCHEDULED APPOINTMENT I WILL BE CHARGED \$75.00. IF THIS IS AN UNCOVERED INSURANCE ITEM I WILL BE RESPONSIBLE FOR PAYMENT. THANK YOU.

SIGNATURE OF PATIENT: _____ DATE: _____

Michael P. Zahalsky, M.D. P.A.
2951 N.W. 49th Avenue, Suite 308, Ft. Lauderdale, FL 33313

NAME: _____ DATE OF BIRTH: _____

List of Reasons for today's visit: _____

MEDICAL HISTORY

Prior Illnesses and Serious Injuries: _____

Prior Surgeries: _____ Date _____

Prior Surgeries: _____ Date _____

Prior Hospitalizations: _____ Date _____

Prior Hospitalizations: _____ Date _____

Please list all the medications you are currently taking: _____

Allergies and Reactions (Drug, Food, Or Other) : _____

Sexually Transmitted Diseases: _____

FAMILY MEDICAL HISTORY

Urology Disease (i.e. Kidney stones, incontinence) ___ mother ___ father ___ other: ___

Please Specify : _____

Cancer ___ mother ___ father ___ other: ___

Please Specify : _____

Social History

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Cohabiting

Living Situation ___ Living at Home ___ Nursing Home ___ Homeless ___ Other

Occupation: _____

Tobacco Use: ___ Non Smoker ___ Smoker: Packs Per Day: _____

Alcohol Use: ___ Non Drinker ___ Yes, I Drink _____ Ounces Per day

Drug Use: ___ Non User ___ User Type: _____

Michael P. Zahalsky, M.D. P.A.
2951 N.W. 49th Avenue, Suite 308, Ft. Lauderdale, FL 33313

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

PRINT NAME: _____ DATE: _____

SIGNED: _____ TELEPHONE: _____

If not signed by the patient, please indicate relationship to patient:

_____ Guardian or conservator of an incompetent patient

_____ Guardian of parent of child (minor)

Name of Patient (please print): _____

PATIENT CONTACT

All call regarding your care, test results and appointments will be made to your home phone number. If you would like us to contact you at an alternate phone number, please indicate that number here:

Preferred Contact Number: _____

_____ I hereby authorize this medical practice to contact me by telephone and I am not present, they may leave a message on my answering machine.

_____ If you prefer that we do NOT leave a message on your machine.

OTHER CONTACT INFORMATION

The following people, other than a duly designated guardian or conservator are authorized to discuss my _____ medical condition and/or _____ billing information with a healthcare professional in this practice:

NAME	RELATIONSHIP	PHONE NUMBER
------	--------------	--------------

NAME	RELATIONSHIP	PHONE NUMBER
------	--------------	--------------

NAME	RELATIONSHIP	PHONE NUMBER
------	--------------	--------------

FOR OFFICE USE ONLY:

Signed form received by (Please Print) : _____ Initials: _____

Acknowledgement Refused: _____

Efforts Obtained: _____

Reasons for Refusal: _____