Michael P. Zahalsky, MD - Mini Varghese, MD - Christopher P. Hollowell, MD - Justin A. Muskovich, MD - Michael Tyler, MD
Melissa Marchand, PA-C - Monika Kulik, PA-C - Jeimy Glaze, PA-C
954-714-8200 Phone 954-840-2626 Fax
www.zurology.com

PERSONAL INFORMATION

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

HOW DID YOU HEAR ABOUT US ?(please circle one and provide the referral source so we may thank them):

Friend / Doctor / Internet Search / Social Media / Website / Media / Other: _____

ADDRESS: _____

HOME PHONE: _____CELL PHONE _____WORK PHONE _____

EMAIL: _____ ***PRIMARY LANGUAGE:*** _____

RACE: _____***ETHNICITY:*** _____ ***PHARMACY NAME /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 # _____

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, lab bills and pathology bills when required. I permit a copy of this authorization to be used in place of the original. Should this account go to collections I will be responsible for all costs of collection and/or attorneys fees. **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. THIS IS AN UNCOVERED INSURANCE ITEM I WILL BE RESPONSIBLE FOR PAYMENT.**

SIGNATURE OF PATIENT: _____ **DATE:** _____

or Signature of Guardian