Advanced Endocrinology & Diabetes CTR, P.C. - Mohamed Firas Zeitoun, M.D.

Patient Information

Name	Birth Date Sex: M F
Address	Telephone
City/State/Zip	Social Security No.
Email Address	Relationship to Guarantor
Employer Name	Employer Phone
Emergency Contact (Other than Spouse)	Emergency Contact Phone
Referred By: Dr. Phone:	Status: Married Single Divorced Widow

Guarantor's Information (if different from Patient's)

Name	Birth Date Sex: M F
Address	Telephone
City/State/Zip	Social Security No.
Email Address	Employer Phone
Employer Name	Status: Married Single Divorced Widow
Employer Address	

How did you hear about this office/practice?

Medical Insurance Information

Primary Insurance:	Policy No. Group No,
Primary Insurance Policy Holder Name	Birth Date Sex: M F
Secondary Insurance:	Policy No. Group No,
Secondary Insurance Policy Holder Name	Birth Date Sex: M F

Is this condition due to an injury? ( ) Yes Accident Date: _____ ( ) No

Where die accident occur? ( ) Work ( ) Home ( ) Car ( ) Other _____

If this is not due to an accident what was the onset date of this condition? _____

Consent and Authorization To Release Information and Assignment of Benefits

I authorize the release of any Medical Information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signature: _____

I hereby authorize Advanced Endocrinology & Diabetes Center PC to apply for benefits on my behalf for covered services rendered by the staff or by their order. I request that payment from my insurance company be made directly to the Center (or to the party who accepts assignment). I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I also hereby authorize and consent to the giving of all treatments, examinations, medications, and any technical procedures which in the judgment of the Dr. Zeitoun and/or his medical staff consider necessary or advisable for diagnosis or treatment. I certify that I have received a copy of HIPPA from this practice. I understand the policies/procedures of this practice and agree to pay $15.00 for any No Call No Show appointments I make.

Date: _____ Signature: _____