DAVID D. ZABEL, M.D., PA, INC.

Date:______________

Patient Name:____Home Phone #:______________

Address:__________________________City:______________State:_______Zip Code:__________

SS#________________Birthdate:__________Age:_____Married/Single/Widowed/Divorced/Partner Sex:_____

Race:____________________ Preferred language:________________ Ethnicity: Hispanic/Non-Hispanic

Email Address:____________________ Cell Phone:______________ Work Phone:____________

Patient/Parent Employer:____________________________Occupation:________________

Employer's Address:____

Spouse's Name________________Employer:__________________Occupation:____________

In Case of an Emergency Contact:______________ Phone #____________ Relationship__________

MEDICAL INFORMATION:

Who referred you (i.e. doctor, friend, hospital):____________________Phone #:______________

Family Physician Name & Address:__________________________ Phone #:______________

Reason for Consultation:____

List All Drug Allergies:__________________________ List Any Recent Surgeries:______________

List Medications Taken Daily:____

Pharmacy Name/Location/Phone Number:____________________________________

Any Personal History of:

Heart Disease................€Yes €No
Diabetes.........................€Yes €No
High Blood Pressure......€Yes €No
Asthma...........................€Yes €No
Liver Disease..................€Yes €No
Kidney Disease...............€Yes €No
Depression.....................€Yes €No
Bleeding Disorder...........€Yes €No

Height________________
Weight________________
Hepatitis..........................€Yes €No
HIV/AIDS..........................€Yes €No
Smoking...........................€Yes €No
# of times/packs per day__________
Poor Circulation...............€Yes €No
Anemia.............................€Yes €No

Psychiatric Care..............€Yes €No
Currently Pregnant.........€Yes €No
Chemical Dependency...€Yes €No
Eating Disorder...............€Yes €No
Anxiety/Panic Disorder.. €Yes €No
Obsessive Compulsive Disorder
€Yes €No
Alcohol Abuse................€Yes €No

INSURANCE/BILLING INFORMATION:

Date first seen by Dr. Zabel______________________ Seen initially at: Hospital Emergency Room Office

Were your injuries from an: AUTO ACCIDENT-☐ Yes ☐ No WORK ACCIDENT- ☐ Yes ☐ No Date of Injury:____________

***if this is an auto accident or workmen's compensation, please refer to the back of the information sheet.**

DO YOU NEED A REFERRAL ☐ Yes ☐ No DID YOU OBTAIN A REFERRAL: ☐ Yes ☐ No

I understand that if I am required to have a referral or authorization for any services rendered at this office and I do not have one, I will be responsible for payment for the services rendered by Dr. Zabel should such services that may be denied by my insurance company for lack of a referral/authorization. SIGNATURE:______________________________

Primary Insurance Company Name:__________________________Phone #______________

Claim Address:____

Subscriber's Name:____________________SS#________________Birthdate:____________

Identification Number:______________________Group/Account #____________________

Secondary Insurance Company Name:________________________Phone #______________

Claim Address:____

Subscriber's Name:____________________SS#________________Birthdate:____________

Identification Number:______________________Group/Account #____________________

Please complete if applicable

WORKMEN'S COMPENSATION

Name of Employer________________________________Supervisor/Managers Name__________________

Summary of How Injury Occurred:____

Date of Accident: ________________________________Date Reported to Employer:________________

Insurance Company:________________________________Claim #:___________________________

Complete Mailing Address:________________________________Phone #:______________________

Adjusters Name:____Phone #:______________________

AUTO ACCIDENT:

Name of Auto Insurance Company: ____

Complete Claim Address: ____

Claim Number (not policy number): ____________________Adjusters Name:________________

Date of Accident: ________________ Attorneys Name & Phone #: ____________________________

OFFICE POLICIES FOR DAVID D. ZABEL, M.D., PA, INC.

- With my consent, Dr. Zabel and his office staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). I also authorize him to call my house or designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any pall pertaining to my clinical care including laboratory results among others. With this consent, Dr. Zabel may mail to my home or other designated location any items that assist the practice in carrying out TPO such as patient statements. By signing this form, I am consenting to Dr. Zabel's use and disclosure in reliance upon my prior consent. If I do not sign this consent, Dr. Zabel may decline to provide treatment to me. I hereby authorize Dr. Zabel to treat me, or my child by medically means he deems necessary or advisable. I further authorize payment of my medical benefits to Dr. Zabel. I understand the above guidelines, have had the opportunity to ask questions and will be given a copy of the privacy notice if I request it.

- In order to treat you as a patient and to submit your claims to the proper insurance company, this information sheet must be **completely** filled out.

- This office must be supplied with all necessary referral and completed claim forms at the time of your visit. It is the responsibility of the patient to make sure your visits are authorized by your insurance company. If your insurance company required referrals/authorizations from your primary care physician, this office must receive the referral/authorization within 10 days. After 10 days, you will be responsible for all bills.

- Payment for office visits must be made at the time of service. If you are involved in a legal matter, payments must still be received on a monthly basis to keep your account in good credit.

- This office allows 60 days after insurance has been filed for the insurance company to make a payment or to receive a response. After this time, the patient is responsible for the balance and also actively pursuing the insurance company to find out the delay in payment.

- Photos taken are the property of Dr. Zabel. Photos may be released to your insurance company to determine medical necessity.

- Work injuries will be filed to the workmen's compensation carrier that has been provided by you. However, any balance not paid by your workmen compensation carrier will be billed to you directly and will be your responsibility.

PATIENT/PARENT SIGNATURE:____