Gail B. Zimmerman, M.D.
Patient Information Sheet

Name _____ Date _____

Phone _____ Cell _____

Email _____

Social Security # _____ Date Of Birth _____

Local Address _____

Permanent Address _____

Occupation _____

Employer _____ Telephone _____

Referred By _____

Circle One: Minor Single Married Divorced Widowed Separated

Spouses Name _____ Telephone _____

Emergency Contact _____ Telephone _____

Relationship _____

Primary Insurance _____

Subscriber # _____ Group# _____ Plan# _____

Name of Responsible Party if Different _____ DOB _____

Address _____

Secondary Insurance _____

Subscriber # _____ Group# _____ Plan# _____

Name of Responsible Party if Different _____

Address _____

Gail B. Zimmerman, M.D.
Patient Information Sheet

Pharmacy _____

Address / Phone Number _____

ARE ANY OF THESE MEDICAL CONDITIONS IN YOUR FAMILY?

DIABETES HYPERTENSION HEART DISEASE ARTHRITIS ULCERS

CANCER THYROID DISORDERS

DO YOU HAVE ALLERGIES? IF SO, LIST THEM BELOW:

_____

ARE YOU ON ANY MEDICATIONS? IF SO, LIST THEM BELOW:

_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS ON MY BEHALF. I AGREE TO BE FULLY RESPONSIBLE FOR ALL LAWFUL DEBTS INCURRED BY MYSELF FOR SERVICES RECEIVED.

PAITENT'S SIGNATURE _____

DATE _____