INTERNAL MEDICINE/PEDIATRICS

19121 WEST LITTLE YORK, SUITE B, KATY, TX 77449

TEL: (713) 955 5200 EMAIL: INFO@ZEALTHCARETX.COM
FAX : (281) 858 1251 WEBSITE: WWW.ZEALTHCARETX.COM

MINOR REGISTRATION

Child's Full Name _____ DOB _____ Age _____

Sex: M F Languages Spoken: _____

Child's Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Child's Race: ☐ American Indian/ Alaskan Native ☐ Asian ☐ White

☐ Black/African American ☐ Hawaiin Native/ Pacific Islander

Home Address _____ City _____State _____Zip_____

HomeTelephone_____Alt.Telephone_____SSN_____

Alternate Contact _____ Relation to Child _____ Telephone_____

Mother's Full Name_____DOB_____SSN_____

Address (if different from child)_____City _____ State _____Zip_____

Mother's Employer _____ Telephone _____

Mother's Work Address _____City _____State _____Zip _____

Mother's E-mail Address _____

Father's Full Name _____DOB_____ SSN _____

Address (if different from child) _____City _____State _____Zip_____

Father's Employer_____ Telephone _____

Father's Work Address _____ City _____State _____Zip_____

Father's E-mail Address _____

Pharmacy Name: _____ Phone: _____

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Siblings Name Age Sex

_____

_____

_____

_____

INSURANCE INFORMATION: ( ) Self Pay ( ) Insurance □ HMO □ PPO □ POS □ EPO □ Indemnity □ Medicaid

Primary Insurance Carrier _____Employer_____

Primary Insurance Policy Holder_____DOB_____Relationship_____

Primary Insurance ID_____Group_____Effective_____

Secondary Insurance Carrier_____Employer_____

Secondary Insurance Policy Holder_____DOB_____Relationship_____

Secondary Insurance ID_____Group_____Effective_____

Treatment Consent

I / authorized person consent to being treated by Dr. Zakir. I also give my consent for prescribing medications if needed. I know there is a separate form for consent for procedures.

Assignment and Release of Information:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to ZealthCare, Ali H. Zakir, MD all insurance benefits if any, otherwise payable to me for services rendered. I understand I am fully responsible for all charges whether paid or not by the insurance company. I hereby authorize ZealthCare to release all information necessary to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

Notice of Privacy Practices and Consent to Use and to Disclose Protected Health Information:

Your protected health information will be used by ZealthCare , Ali H. Zakir, MD or disclosed to others for the purposes of treatment, obtaining payment, or supporting day-to-day healthcare operations of the practice. ZealthCare , Ali H. Zakir, MD reserves the right to modify the privacy practices outlined in the privacy notice. Notification will be served upon a change. I have reviewed the brochure “Notice of Privacy Policies and Practices” and give my permission ZealthCare , Ali H. Zakir, MD to use and disclose my health information in accordance with this consent and the notice provided.

Sign_____Date_____ Relationship_____

Print Name_____