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

ALI H. ZAKIR, MD

Registration Form

Name:

_____

(*Last name)* *(First name)* *(M.I.)*

Sex : M F Age : Date of Birth / / S.S. Number / /

Address:

_____

(*Street)* (*Apt #)*

_____

(*City)* (*State)* (*Zip)*

Phone: R.(____)_____O. (____)_____ cell. (____)_____

Email Address: _____

Languages Spoken: _____

Ethnicity: ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race: ☐ American Indian/ Alaskan Native

☐ Asian

☐ White

☐ Black / African American

☐ Hawaiin Native/ Pacific Islander

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Employer: _____

Retired: Y N If yes, date _____ Marital status: M S W D

Insurance(s) : _____ Copay (if any) : _____

Insurance under (if different) _____
Last name *First name*

Date of Birth / / S.S. Number / /

Relationship _____Employer: _____

Emergency Contact_____ Phone_____ Relationship_____

Pharmacy Name: _____ Phone: _____

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.

Signed: Patient_____ Authorized person_____

Date: _____ *Relationship to patient:* _____

I authorize the payment directly to Dr. Zakir for services rendered to me. A copy of this authorization may be used in place of the original. I understand that I am financially responsible for charges not covered by my insurance. I authorize the release of any medical or other information necessary to process this claim.

Signed: Patient _____ Authorized person _____

Date: _____ *Relationship to patient:*_____