MANI H. ZADEH M.D., F.A.C.S.
HEAD & NECK SURGERY | EAR, NOSE & THROAT

Name: ____________________ **Date of Birth:**___/___/___ **Age:** ______
Last First Middle Mo Day Yr

□ Male □ Female Marital Status:________________ Name of Spouse: ________________

If Minor, Name of Parent or Responsible Party: ______________________________

Address: ______________________________ **Apt No:** ______

City: ____________________ **State:** ______________ **Zip:** __________

Social Security No: ____________________ **Occupation:** ____________________

Driver's License: ____________________ **Employer:** ____________________

Telephone: Home: ____________________ Work: ____________________

Cell: ____________________ Email: ____________________

Insurance Company: ____________________ **I.D. Number:** ____________________

Insured Name: ____________________ **Insured Date of Birth**: ___/___/___
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Whom shall we thank for referring you? ______________________________

Personal Physician: ____________________ **Emergency contact:** ____________________

Telephone: ____________________ **Telephone:** ____________________

Relationship: ____________________

May we send your physician a report of our findings? □ YES □ NO

AUTHOTIZATION:
I authorize the release of medical information to my insurance company: □ YES □ NO

BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

The insurance company is hereby authorized to pay all benefits directly to my attending physician.
If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager.

I have read the above policy and understand my financial responsibility.

Signature: ____________________ **Date:**___/___/___
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