Marianne Zakarian, M.D., P.C.
Obstetrics and Gynecology

PATIENT REGISTRATION

NAME____
(LAST) (FIRST) (MIDDLE)

BIRTHDATE ____________ SOCIAL SECURITY NUMBER ____________ MARITIAL STATUS ____________

MAILING ADDRESS ____

CITY ____________ STATE ____________ ZIP ____________

BILLING ADDRESS (IF DIFFERENT FROM MAILING) ____

CITY ____________ STATE ____________ ZIP ____________

HOME PHONE NUMBER ____________ CELL/ALTERNATE NUMBER ____________

EMPLOYER NAME ____________ OCCUPATION ____________ EMPLOYER PHONE ____________

SPOUSE NAME/PARENTS (IF MINOR) ____

BIRTHDATE ____________ SOCIAL SECURITY NUMBER ____________

SPOUSE EMPLOYER ____________ OCCUPATION ____________ EMPLOYER PHONE ____________

IN CASE OF EMERGENCY, CONTACT____
(NAME) (PHONE)

NAME OF PERSON WHO REFERRED YOU TO US______________________________

PATIENT SIGNATURE______________________________ **DATE**____________

WE ASK FOR PAYMENT AT THE TIME OF SERVICE. WE WILL SUBMIT SELECTED INSURANCE CARRIER CLAIMS AS A COURTESY TO YOU (IDAHO ONLY).

PRIMARY INSURANCE____

SUBSCRIBER NAME____

BIRTHDATE____________ SOCIAL SECURITY NUMBER____________

INSURANCE ID/GROUP NUMBER____

I ACKNOWLEDGE THAT I AM FULLY RESPONSIBLE FOR THIS MEDICAL BILL. I HEREBY AUTHORIZE MARIANNE ZAKARIAN, MD,PC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MEDICAL SERVICES RENDERED AND I HEREBY IRREVOCABLY ASSIGN THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. NOTE: ANY PATIENT WHO HAS NOT SHOWN FOR AN APPOINTMENT WITHOUT NOTIFYING THIS OFFICE AT LEAST 24 HOURS IN ADVANCE MAY BE CHARGED FOR THE MISSED APPOINTMENT, BASED ON THE TIME ALLOWED FOR THE APPOINTMENT. AFTER THREE NO SHOWS WITHOUT NOTIFICATION, THE PATIENT (MYSELF) WILL BE REMOVED FROM THE PRACTICE. ANY PATIENT ACCOUNT THAT HAS GONE UN-PAID WILL BE SET UP WITH A BILLING SERVICE WITH A $20.00 SET UP FEE AND FINANCE CHARGE OF UP TO 18%. RETURNED CHECKS WILL ALSO BE ASSESSED AN ADDITIONAL FEE OF $25.00.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **DATE**

____
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

2536 N. Stokesberry Place, Meridian, Idaho 83642