ZealthCare Medical Clinic
Internal Medicine/Pediatrics
19121 West Little York, Suite B, Katy, TX 77449
Tel: (713) 955 5200 Email: contact@zealthcaremedical.com
Fax: (281) 858 1251 Website: www.zealthcaremedicalclinic.com

Patient Registration Form

NAME: _____
Last First M.I.

EMAIL: _____ BIRTH DATE:____/_____/____

SEX: □ Male □ Female **RACE/ETHNIC:** □ White □ African-Amer. □ Asian □ Hispanic/Latino □ Other

ADDRESS: _____
Street, Apt., City, State, Zip

PHONE: HOME _____-_____ CELL:_____-_____ OFFICE _____-_____

INSURANCE : _____
Company , Member ID

EMERGENCY CONTACT _____ _____ _____
Name Relationship Phone

PHARMACY NAME : _____ PHONE: _____

ALLERGIES to foods or medicines:_____

REASON FOR VISIT : _____

HOW DID YOU LEARN ABOUT ZealthCare Medical Clinic: (CHECK ALL THAT APPLY**)**
□ I have been here before □ Referred by my doctor/clinic (name, phone) _____
□ Web search □ Referred by my school/employer (name) _____
□ Ad □ Referred by my friend/family/other (name) _____

Consent for Medical Care, Record Keeping, Privacy Notice, and Payment Responsibility

I, as the client/patient, agree to receive care from a health care provider at the ZealthCare Medical Clinic. I give consent for examination, immunization, blood or skin testing, medical advice, prescribing medications if needed and other services from my provider.
(2) I understand that it is my responsibility to pay for services received. 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.
(3) I acknowledge that I have had the opportunity to read or receive a copy of the "Notice of Privacy Practices".
(4) ZealthCare Medical Clinic will keep this record in you or your child's medical file.
(5) By signing the form below, you hereby freely and voluntarily give your permission and are requesting that the vaccine(s) and/or test(s) be given to you or the person named below for whom you are authorized to make this request.
(6) I understand the risks and benefits of the test/vaccine being given to me and have the opportunity to read The Vaccine Information Sheet "VIS" on each vaccine, or a "Subject Information" pamphlet on each test, as stated by law, for me to read BEFORE I receive your shots and/or test(s). Your signature below indicates that you have read, or have had the information explained to you and that you understand the benefits and risks of each vaccine administered. You hereby release and agree to hold harmless ZealthCare Medical Clinic, its Officers, and Employees for any and all liability, of any kind or nature whatsoever, which might arise out of or result from any vaccine(s) and/or test(s) administered to you or your child.

Signed: _____ Date:_____

If client is a minor:
Print name of parent/ guardian: _____