

DANIEL ZACHARIAS, M.D.
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Patient's name _____

Address _____

PHONES: home _____ cell _____

work _____ email _____

date of birth

emergency contact name and number

INSURANCE:

policyholder name

policyholder birthday

patient's relationship to the policyholder

policy number

group number

address of insurance co

I hereby assign, transfer and set over to Dr. Zacharias, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I consent to review of my previous medical information including prescription history. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature: _____ date: _____

The following pages of medical items are listed to cue issues to go over at your appointment. This is only a guide to identify issues to discuss. Please evaluate each item but you don't need to answer each of them. If you need more space, use more space!

The main reason for making this medical appointment:

Medical problems and treatments:

Past/Current Medical Conditions

Anemia
Arthritis.
Asthma.
Bronchitis.
Cancer.
Chronic fatigue syndrome.
Crohn's disease or ulcerative colitis.
Dental/Periodontal disease
Diabetes.
Emphysema.
Epilepsy, convulsions, seizures.
Gallstones.
Heart disease.
Heart failure.
Heart irregularity
Hepatitis.
Hyperlipidemia (high cholesterol, triglycerides).
High blood pressure (hypertension).
Irritable bowel.
Lyme, tickborne illness
Kidney stones.
Mononucleosis/Epstein Barr virus
Neurologic disorder (e.g. MS, Parkinson's, neuropathy)

