Linda L. Zeineh, M.D.
Board Certified Plastic Surgeon

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PATIENT & INSURANCE INFORMATION (ADULT)

First Name: _____ MI: _____ Last Name: _____ Birthdate: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell #: _____ Work Phone #: _____
Male ☐ Female ☐ Marital Status: _____ Occupation: _____
Ethnicity: American Indian ☐ Asian ☐ Hispanic ☐ African American ☐ Native Hawaiian ☐ Caucasian ☐
Language Spoken: _____
Social Security #: _____ Driver License #: _____
Employer (name & address): _____

_____

Name of spouse: _____ Occupation: _____
Employer's name, address & phone #: _____

_____

Social Security #: _____ Birth Date: _____
Who referred you to my office? (If a physician, include address & phone #): _____

_____

Close friend or relative (not living with patient) (name, address & phone #): _____

_____

PRIMARY INSURANCE CARRIER:

Company Name: _____
Claims Billing Address: _____
Subscriber (Insured): _____ Relationship to Patient: _____
Policy Holder (If Group): _____ SS#: _____ DOB: _____
Group or Policy #: _____ Certificate #: _____

SECONDARY INSURANCE CARRIER:

Company Name: _____
Claims Billing Address: _____
Subscriber (Insured): _____ Relationship to Patient: _____
Policy Holder (If Group): _____ SS#: _____ DOB: _____
Group or Policy #: _____ Certificate #: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Dr. Zeineh to release to my insurance carrier any and all information that might be required in order to evaluate my claim (or potential claim) for insurance benefits pertaining to myself and/or my dependent. I hereby authorize my insurance carrier to pay, and hereby assign directly to Dr. Zeineh any and all benefits otherwise payable to me for her services. I understand that I am financially responsible for all charges incurred over and above those benefits that may be paid directly to Dr. Zeineh by my insurance carrier. A copy of this assignment shall be considered as valid as the original.

Authorized signature _____ Date _____

EMAIL AUTHORIZATION

I hereby authorize Dr. Zeineh and/or the staff of Dr. Zeineh to use my email address to send me information regarding my medical care, appointments, or to give me information about products or services that may be of interest to me.

Email Address _____

Authorized signature _____ Date _____