Atef S. Zakhary, M.D.

PATIENT INFORMATION

Last Name	First Name:		Social Security Number:
Date of Birth:			
Street Address		Apartment Number:	City, State, Zip
Home Phone	Work Phone		Cell Phone
Marital Status: Married Single Divorced (circle one)	Preferred Language:		Ethnicity: (Optional) (circle one) Hispanic or Latino Not Hispanic or Latino
Email: (If you would like access to MyChart – Patient Portal)			Race: (Optional) (Circle One) Black White Asian Other: _______________
Employer Name:	Employer Phone number:		

PRIMARY CARE PHYSICIAN

Primary Care Physician	Primary Care Physician Phone Number:

INSURANCE INFORMATION

Name of Insurance	ID#
Policy Holder's Name if Other Than Patient	Policy Holder's DOB
SECONDARY INSURANCE (Write "NONE" If NOT Applicable)	ID#
Policy Holder's Name if Other Than Patient	Policy Holder's DOB

EMERGENCY CONTACT INFORMATION

Name		
Contact #	Relationship to Patient	

I attest the above information to be true and accurate. I understand that any services sent to lab or pathology is a separate service and I may receive a bill from those providers. I authorize Omni Medical Center for Women to release any medical information necessary to process claims, coordinate care, referrals and for quality management and/or utilization activities. *I understand that it is my responsibility to notify Omni Medical Center for Women of any changes in address, phone number and/or insurance information.* I authorize payment of medical benefits to Omni Medical Center for Women for services rendered.

Signature: **Date:**

706 W Platt St.
Tampa, FL 33606

6101 Webb Rd Ste., 102
Tampa, FL 33615

Ph.: 813-251-2000 **www.omc4women.com** **Fax: 813-283-6700**