RICHARD D. ZEPH, M.D.F.A.C.S.
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY
13590-B NORTH MERIDIAN STREET, SUITE 201
CARMEL, IN 46032
(317) 573-7887 OR (800) 352-1056

MEDICAL QUESTIONNAIRE UPDATE

Welcome, we are delighted to see you again! Please take a few minutes to help us update our records.

Name _____ Date _____

Address:_____

Home Phone: (_____)_____Cell Phone: (_____)_____

Birthdate_____Email Address_____

(REQUIRED) Pharmacy Name_____

Address_____Phone (_____)_____

Has your name changed since your last visit here? _____Yes _____No
If yes, what was the old name? _____
What name do you use for health insurance if different than above?
_____
Has your marital status changed? _____ Yes _____ No
Has your employment changed? _____ Yes _____ No
Please indicate your new employer name, address and phone number:
_____
Have you changed health insurance companies? _____ Yes _____ No
If yes, please indicate your health insurance carrier, address and phone number:

Primary	Secondary
_____	_____
_____	_____
Group # _____	Group #_____
Subscriber # _____	Subscriber # _____

Who is responsible for this bill? _____

Please note any changes in your health since your last visit?

Illness _____

Accident _____

Allergies _____

Medications being taken _____

Other_____

PLEASE CONTINUE ON THE BACK

I acknowledge I am financially responsible for any services rendered by Richard D. Zeph, M.D.:

Signature:_____ Date_____

(IF APPLICABLE) Signature of parent of minor child or legal guardian of patient:

_____ Date_____

If the hospital or our office should need to contact you, at what number(s) can you be reached?

_____

Do they/we have your permission to leave a message on the voicemail/answering machine?

_____

Do they/we have your permission to speak with your spouse/family member/significant other?

_____

Medical Insurance Release

I authorize the release of medical information including photographs necessary to process any claim for services provided by Dr. Zeph. I further authorize the release of medical benefits to Dr. Zeph. A copy of this authorization may be used in place of the original. I understand the Doctor's charges may exceed my insurance carriers allowable payment, and if this should occur, I realize I will be responsible for that portion. **All of the follow up appointments will be covered under the initial surgery fee for the first 60 days. After that time period, your insurance will be billed appropriately.**

Signature:_____ Date_____

(IF APPLICABLE) Signature of parent of minor child or legal guardian of patient:

_____ Date_____