**PATIENT INFORMATION**
For
**MICHAEL A. ZIMMER M.D., F.A.C.P**
**509 JACKSON STREET NORTH**
**ST. PETERSBURG, FL 33705**
**PHONE 727-820-7800 FAX 727-820 7801**

**PATIENT NAME_____DOB_____ SS NUMBER_____**

**ADDRESS _____ HOME PHONE _____**
(INCLUDE
ZIP CODE) _____ **WORK PHONE _____**

**AGE _____ SEX: M F MARITAL STATUS _____ EMERGENCY CONTACT:**
**NAME_____**
**ADDRESS _____**
**PHONE_____**
**EMAIL_____**

**INSURANCE INFORMATION**
**(NECESSARY)**

**PRIMARY INSURANCE _____**
(INSURANCE TO BE FILED FIRST)
**INSURANCE ID # _____ GROUP #_____**

**INSURANCE ADDRESS _____ INSURANCE PH #_____**

**NAME OF POLICYHOLDER _____**

**IF OTHER THAN SELF: DATE OF BIRTH _____ EMPLOYER _____**

**SECONDARY INSURANCE _____**
(INSURANCE FILED AFTER PRIMARY)
**INSURANCE ID # _____ GROUP # _____**

**INSURANCE ADDRESS _____**

**INSURANCE PHONE # _____**

**NAME OF POLICYHOLDER _____**

**IF OTHER THAN SELF: DATE OF BIRTH _____**

**EMPLOYER _____**

***PLEASE NOTE THAT INACCURATE OR UNAVAILABLE INSURANCE INFORMATION WILL RESULT IN THE PATIENT BEING RESPONSIBLE FOR PAYMENT.***

**PATIENT INFORMATION**

**DO YOU HAVE A LIVING WILL?** ◯ **YES** ◯ **NO**
**DO YOU HAVE AN ADVANCED DIRECTIVE?** ◯ **YES** ◯ **NO**
**WHO REFERRED YOU TO DR. ZIMMER? _____**

**SIGNATURE _____ DATE _____**