## MANDATORY YEARLY UPDATE INFORMATION

**PATIENT RESPONSIBILITY**

**I hereby authorize Michael A. Zimmer M.D. and associates to bill my primary, secondary and tertiary insurance companies for payment of services rendered. I understand all co-payments, deductibles and out of pocket expenses are my responsibility and liability.**
**I understand that if my insurance companies do not pay for non-covered charges I am responsible for any and all balances due. I also understand that it is my responsibility to inform the practice of any insurance coverage changes or lapses at the time of my visit or prior as to not delay payment for services.**

**CONFIDENTIALITY**
**Please list the family members or significant others, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options).**

**NAME_____Phone number _____**

**NAME_____Phone number _____**

**Please list the family members or significant others, if any, whom we may inform about your medical condition only in an emergency.**

**NAME_____Phone number _____**

**NAME_____Phone number _____**

**MEDICAL UPDATE**
**Please list ALLERGIES or SENSITIVIES to medication:**

| MEDICATION | TYPE OF REACTION |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |

**Social History / Habits**

**Do you smoke now? Y or N Did you ever smoke? Y or N How much? _____ How long? _____**

**Do you drink alcohol? Y or N If yes, how much per week? _____**

**I hereby give consent for the office of Michael A. Zimmer PLC to retrieve my medication history from pharmacies and/or pharmacy benefit managers that I patronize.**

**SIGNATURE_____DATE_____**