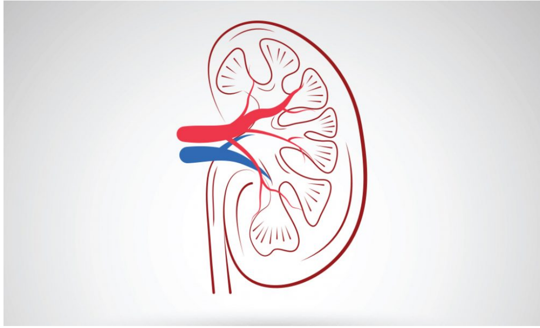

Fuad Afzal, MD and Sayed Husain, MD -- Nephrology
Mid- Florida Kidney and Hypertension Care PL
631 Palm Springs Dr. Suite 104
Altamonte Springs, FL 32701
Ph: 407-265-2540 Fax: 407-265-9167

PATIENT REGISTRATION

Date: ________________________

Patient's Legal First Name: ___________________________ **Last Name**:_______________________

Sex: ___F ___M **Date of Birth**: ____/____/______

HomeAddress:____
Street City State Zip

SecondaryAddress:____
Street City State Zip

Home Phone: _________________**Work Phone**: ___________________**Cell Phone**:_______________

Employer:__________________________ **Social Security#**: ________________________________

Preferred Contact : Home ____ Cell ____

May we leave a message on your answering machine / voicemail? Yes ____ No ____

Email:____ **May we email you?** Yes ____ No ____

Preferred Language: _______________________________

Ethnicity/Race: American Indian or Alaska Native ___ Hispanic or Latino ___ Asian ___
Black or African American ___ Native Hawaiian or other Pacific Islander ___ White or Caucasian ___

Employment Status: Employed ___ Unemployed ___ Retired ____ Disabled ____

Employer Name: __________________________ **Phone number:** _____________________________

Pharmacy Name: ________________________ **Pharmacy Phone #:** ___________________________

Advance Directives: Yes ____ No ____ If yes, provide directed person's full name:
_________________________________ And provide directed person's Phone: ___________________

EMERGENCY INFORMATION

Please list a friend or relative (not of the same address) to contact in case of any emergency

Name:____________________________________ Relationship:_____________ Phone: ____________

Last First M

REFERRING DOCTOR/PRIMARY DOCTOR INFORMATION

Referring Physician: ______________________________ **Phone:**___________________________

Primary Care Physician:___________________________ **Phone:**__________________________

Other Physician you see:

____ **Phone:** _____________________________

____ **Phone:** _____________________________

____ **Phone:** _____________________________

PRIMARY INSURANCE:

Primary Insurance: ___________________________________ Phone #:__________________________

Policy/ID #: ___________________________________ Group Number:________________________

Name of Policy Holder:____ Relationship:__________

Policy Holder SS #:________________________ Policy Holder DOB: _____/_____/_____

Policy Holder Employer:____

SECONDARY INSURANCE:

Secondary Insurance: ______________________________ Phone Number: ________________________

Policy/ID #: ___________________________________ Group Number: ________________________

CONSENT FOR YOU TO BE PHOTOGRAPHED

I authorize Mid- Florida Kidney and Hypertension Care PL to take my photograph for the purpose of patient identification and for medical record electronic systems. By signing this, I authorize for the above purpose.

____________________________________ ____________________________________

Patient Signature Patient Printed Name

Consent For Prescription History:

This Consent is Valid during the entire term of my association with **Mid-Florida Kidney and Hypertension Care, PL Fuad Afzal, MD and/or Sayed Husain, MD** and may be relied upon by **Mid-Florida Kidney and Hypertension Care, PL Fuad Afzal, MD and/or Sayed Husain, MD** unless, and until, revoked by patient or those acting for patient, in writing. Knowing that I am suffering from a condition requiring medical treatment, I, ______________________________________, do hereby Voluntarily consent to running of All of my entire Prescription history as are necessary in the judgement of the physician(s) in charge. I am Aware giving consent to **Mid-Florida Kidney and Hypertension Care, PL Fuad Afzal, MD and/or Sayed Husain, MD** that Prescription history will contain information from all prescribing providers.

Patient Name:______________________________________ **Patient DOB:__________________**

Patient Signature :___________________________________ **Date:_____________**

Consent Authorization to Release Information:

I hereby authorize my doctor **Fuad Afzal, MD and/or Sayed Husain, MD** to release any information or incidental information that may be necessary for either medical care or in the procession of my insurance benefits. I hereby authorize direct payment of medical benefits to my doctor **Fuad Afzal, MD and/or Sayed Husain, MD** for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by insurance (either copays or total amount of charges) if insurance does not pay.

Patient Name:______________________________________ **Patient DOB:__________________**

Signature:____ **Date:__________________________**

CONSENT FOR TREATMENT

This consent is valid during the entire term of my association with **MFK -- Fuad Afzal, MD and Sayed Husain, MD** and may be relied upon by **MFK -- Fuad Afzal, MD and Sayed Husain, MD**, unless, and until, revoked by patient or those acting for patient, in writing. Knowing that I am suffering from a condition requiring medical treatment, I do hereby voluntarily consent to such diagnostic procedures as are necessary in the judgment of the physician **MFK -- Fuad Afzal, MD and Sayed Husain, MD** in charge. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examination or treatment in the hospital or office.

Patient Name:______________________________________ **Patient DOB:__________________**

Signature:____ **Date:__________________________**