Faizun Anwar, MD, P.A.
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PATIENT REGISTRATION FORM

How did you hear about us?_____

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**
Date of Birth (MM/DD/YYYY):	**Sex:** ☐ **Male** ☐ **Female** ☐ **Other**	**Social Security #:**
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**	**Employment:** ☐ **Full-time** ☐ **Part-time** ☐ **Unemployed**	**Student:** ☐ **Full-time** ☐ **Part-time**
Ethnicity: ☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino** ☐ **Prefer not to answer**	**Race:** ☐ **Asian** ☐ **Black/African American** ☐ **White** ☐ **Other**	**Preferred Language:**
Street Address:	**City:**	**State:** **ZIP:**
Home Phone:	**Cell Phone:**	**Email:**

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

Name:	**Relationship to Patient:**	**Date of Birth:**
Street Address:	**City:**	**State:** **ZIP:**
Home Phone:	**Cell Phone:**	**Social Security #:**

INSURANCE INFORMATION

PRIMARY INSURANCE - Policy Holder Name:	**Relationship to Patient:**	**DOB:**
Insurance Company:	**Policy/ID #:**	**Group #:**
Employer/Plan Sponsor:	**Insurance Phone:**	
SECONDARY INSURANCE - Policy Holder Name:	**Relationship to Patient:**	**DOB:**
Insurance Company:	**Policy/ID #:**	**Group #:**

EMERGENCY CONTACT

Name:	**Relationship to Patient:**	**Cell Phone:**
Home Phone:	**Work Phone:**	**Address:**

PREFERRED PHARMACY

Pharmacy Name:	**Phone:**	**City/Location:**

I certify that the information above is complete and accurate. I authorize this practice to release medical information necessary to process insurance claims and to receive payment directly from my insurance carrier. I understand that I am financially responsible for charges not covered by insurance. I acknowledge receipt of the Notice of Privacy Practices.

Patient/Guardian Signature:	**Date:**

What is the reason for today's visit?

_____

Drug Allergies:

_____

_____

Current Medicines:

_____

_____

List Chronic Medical Problems:

_____

_____

_____

Surgeries:

_____

_____

For Women Only

LMP:_____

Last Pap Smear:_____

Last Mammogram:_____

# of Pregnancies_____

For Men Only

Last Prostate Exam:_____

Last Testicular Exam:_____

Do You:

Smoke? Y N # of cigarettes/day?_____

Drink Alcohol? Y N # of drinks per week?_____

Use other Drugs? Y N How often?_____

Do you exercise regularly? _____

Do you have a Living Will? _____

Social History: Married or Single

Employment _____

# of Children _____

REVIEW OF SYSTEMS: Do you or have you ever had chronic problems with?

Eyes Y N
Ears Y N
Headaches Y N
Nose Y N
Throat Y N
Breathing Y N
Heart Y N
Chest Y N
Lungs Y N
Stomach Y N
Food Digestion Y N
Intestines Y N
Rectum Y N
Constipation Y N
Diarrhea Y N
Bladder Y N
Kidneys Y N

Ovaries Y N
Uterus Y N
Cervix Y N
Menstruation Y N
Blood Disorders Y N
Immune Deficiency Disorder Y N
Testicles/Penis Y N
Sexually Transmitted Disease Y N
Skin Y N
Legs-Arms Y N
Depression Y N
Emotional/Illness Y N
Sleep Problem Y N
Personal/Work Stress Y N

FAMILY HISTORY OF: WHO
Cancer
Type: _____
Type: _____
Type: _____
Heart Disease:
Heart Attack:
High Blood Pressure:
Strokes:
Blood Disease:
Diabetes:
Seizures:
Mental Illness:
Asthma:
Osteoporosis:
Other

Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time service. For your convenience we accept VISA and MasterCard.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept and assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This office's policy is to collect this co payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurance will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms.
I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Anwar's Clinic for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Anwar's Clinic to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Anwar's Clinic on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

CANCELLATION/NO-SHOW POLICY FOR FAIZUN ANWAR, MD, PA

1. **Cancellation/No Show Policy for Appointment-** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book. If an appointment is not cancelled at least **24 hours** in advance you will be charged a **$25** fee; this will not be covered by your insurance.

2. **Scheduled Appointments-** We understand that delays can happen; however we must try to keep the other patients on time. If a patient is **15 minutes** past their scheduled time, you will have to reschedule the appointment.

Print Name Patient **Signature Patient/Guardian** **Date**