**Florida Infectious Disease Specialists, INC.**

102 Park Place Blvd, Bldg. D Suite #2 & 3, Kissimmee FL, 34741

**Patient Information**

**Personal info:** Last: _____ First: _____ Middle: ____ Suffix: _____ Gender: M/F

Marital Status: Single: ___ Married: ___ Divorced: ___ Widowed: ___ **Email:**_____

Home Address: Street: _____ Apt #: ____ City:_____ State: ___ Zip: _____

Home Phone: _____ Cell: _____ Other: _____

Date of Birth: ___/___/_____ S.S.#: _____ _____ _____ Driver's License #: _____

Occupation: _____ Work Phone: ( ) _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Employer's Phone Number: ( ) _____

Referred By Dr. _____ Hospital: _____

Primary care Dr.: _____ Phone: ( ) _____

**Name of Preferred Pharmacy:**_____ **Pharmacy Phone #:** _____

**Address:** _____ **City/State:** _____ **Zip:** _____

**Primary Health Insurance:**

Subscriber's name: _____ Insurance Company: _____

ID#: _____ Group #: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: ( ) _____

**Secondary Health Insurance:**

Subscriber's name: _____ Insurance Company: _____

ID#: _____ Group #: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone Number: ( ) _____

**In case of emergency contact:** Name: _____ Phone: _____

I hereby given my consent to Florida Infectious Disease Specialist (FLIDS) to provide medical treatment to me as my physicians. I hereby authorize and direct payment of my medical benefits to FLIDS on my behalf for any services furnished to me by the providers. I also solemnly affirm that the information provided by me is correct and up to date to the best of my knowledge. I will promptly notify FLIDS about any changes in this information.

Signature: _____ Date: _____

Florida Infectious Disease Specialist, Inc.

Sajid Chaudhary, M.D / Shoaib Siddiqui, M.D / Mehmood Nawab, M.D / Nida Hameed, M.D

## Patient's Health History

Name: Last: _____ First: _____ Middle: _____ DOB: _____

Medication Allergies: _____

Current Medication (including over the counter): _____

_____

_____

**Current Medical Problems**: Please Circle all that applies now:

| | | | | | |
|---|---|---|---|---|---|
| Shortness of Breath: | Y/N | Abdominal Pain: | Y/N | Blurring Vision: | Y/N |
| Chest Pain: | Y/N | Nausea: | Y/N | Fever: | Y/N |
| Diarrhea/Constipation: | Y/N | Pain in the joints: | Y/N | Headache: | Y/N |
| Swollen ankles: | Y/N | Palpitations: | Y/N | Cough: | Y/N |
| Wheezing: | Y/N | Ear ache: | Y/N | Urine problem: | Y/N |
| Loss of Weight: | Y/N | Dizziness: | Y/N | Weakness: | Y/N |
| Change in appetite: | Y/N | Other: _____ | | | |

Please explain in detail the option selected: _____

_____

**Past History:**

| | | | | | |
|---|---|---|---|---|---|
| Heart problems: | Y/N | Thyroid Disease | Y/N | Jaundice: | Y/N |
| High Blood Pressure: | Y/N | Kidney Problems: | Y/N | Cancer: | Y/N |
| Skin Disease: | Y/N | Venereal Diseases: | Y/N | Seizures: | Y/N |
| Blood Disorder: | Y/N | HIV: | Y/N | Anemia: | Y/N |
| Hearing Defect: | Y/N | Chest Infection: | Y/N | Hemorrhoids: | Y/N |
| Gout: | Y/N | Diabetes: | Y/N | Asthma: | Y/N |

Other: _____

Any Surgeries: 1) _____ Dates: _____ 2) _____ Dates: _____

3) _____ Dates: _____ 4) _____ Dates: _____

Dates of LAST Physical Exam? _____ Do you Smoke? Y/N Do you use illicit drugs? Y/N

Do you Drink alcohol? Y/N How often & How Much _____ Living will? Y/N

| **Family History:** Check all that apply. | Mother | Father | Siblings | Children |
|---|---|---|---|---|
| Cancer. | | | | |
| Diabetes. | | | | |
| Epilepsy/Convulsions. | | | | |
| Heart Disease. | | | | |
| High Blood Pressure. | | | | |
| Kidney Disease. | | | | |
| Thyroid Disease. | | | | |

I hereby solemnly affirm that I have provided this information to the best of my knowledge.

Signature: _____ Date: _____

**Florida Infectious Disease Specialist, Inc.**
**Dr. Sajid Chaudhary, M.D / Dr. Shoaib Siddiqui, M.D / Dr. Mehmood Nawab / Dr. Nida Hameed**
102 Park Place Blvd, Bldg. D Suite #2 & 3, Kissimmee FL, 34741

## Individual's financial responsibility:

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payment are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the even that my health plan determines a service to be "not payable, I will be responsible for the complete charge and agree to pay the cost of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

## Medicare Request for Payment:

I request payment of authorized Medicare benefits to be or on my behalf for any services furnished me by or in FLIDS. I authorized any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits fir related services.

## Consent for Treatment:

I hereby give consent to FLIDS to provide whatever treatment may deem necessary to the patient

_____.

## Confidentiality Clause:

I authorize the verbal or written release of my information and test result to my family members in the event that I am not available.

Circle one: Yes No

Patient Signature: _____ Date: _____

Specific family member authorized: _____

Relationship to the patient: _____

## Authorization to release records:

I hereby authorize Florida Infectious Disease Specialist to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

_____ _____
Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative of Responsible party Relationship to Patient

## Florida Infectious Disease Specialist, Inc.

**Sajid Chaudhary, MD. / Shoaib Siddiqui, MD. / Mehmood Nawab, MD. / Nida Hameed, MD.**

**Acknowledgement of receipt of Privacy Notice:**

I have received a copy of the Privacy notice from
Dr. Sajid Chaudhary, M.D / Dr. Shoaib Siddiqui, M.D / Dr. Mehmood Nawab / Dr. Nida Hameed

Signature: _____

Name: _____

Date: _____