REGISTRATION
(PLEASE PRINT)

ZOOVIA HAMIDUDDIN, M.D.
175 Memorial Highway
Suite 1-15
New Rochelle. New York 10801
Tel. 914 636-3626

Date _____ Home Phone _____

Patient _____
Last Name First Name Initial

Responsible Party (if a minor) _____

Street Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse (or responsible party) Name _____ Birthdate _____

Business Name and Address _____

Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐ No ☐ Yes ▶ If yes,

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

☐ Medicare ☐ Medicaid Claim ID # _____

If Welfare, your number _____ County of _____

In case of emergency, who should be notified? _____ Phone _____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

#10501 — Medical Arts Press 1-800-328-2179

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononeucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

Pharmacy Name_____ Phone_____

ALLERGIES To medications or substances

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

_____ Reviewed By

_____ Date

Dr. Zoovia Hamiduddin

Patient Name _____ D.O.B. _____ Date _____

At the request of the Federal Government, Dr. Zoovia Hamiduddin has implemented an electronic medical record, designed to increase the quality, safety and efficiency of your health care. Please provide the information requested. It will be stored in your personal electronic health record and safeguarded under HIPPA, the same federal law that protects your paper records.

Please list current medications:

_____

_____

_____

Please list allergies/sensitivities to medications. Indicate any reaction that occurred:

_____

_____

Please select the category mat best indicates your smoking history:

_____ Current every day smoker _____ Current some day smoker _____ Current status unknown
_____ Former smoker _____ Never smoked _____ Unknown if ever smoked

If you are a woman age 40-69 have you ever had a mammogram to screen for breast cancer?

_____ Yes _____ No _____ Unknown

If you are age 50-75 years of age, have you been screened for colorectal cancer?

_____ Yes _____ No _____ Unknown

Ham you ever received an influenza (flu) vaccine?

_____ Yes _____ No _____ Unknown

If you are age 64 or older have you ever received a pneumonia vaccine?

_____ Yes _____ No _____ Unknown

DEMOGRAPHICS

Please select your ethnic background:

_____ Hispanic or Latino _____ Not Hispanic or Latino _____ No Response

Please select your race:

_____ American Indian/ Alaska Native _____ Hawaiian or Pacific Islander _____ Asian
_____ Black or African American _____ White _____ No response
_____ Other

What is the primary language spoken in your home?

___ English ___ Spanish ___ Arabic ___ Japanese ___ Russian ___ Cantonese
___ Korean ___ Mandarin ___ Hebrew ___ No response

Patient Signature _____

Zoovia Hamiduddin, M.D.
175 Memorial Highway • Suite 1-15
New Rochelle, New York 10801
Tel: 914-636-3626 Fax: 914-636-3670

Office Policy

I am aware that it is my responsibility to provide complete and correct insurance billing information, including presentation of my current insurance card to Dr. Zoovia Hamiduddin and staff.

I understand that failure to present correct billing information at the time of service may result in denial from my insurance plan. This includes correct effective and/or termination dates. In this event, I understand that I will be billed for services rendered by Dr. Hamiduddin. I am responsible for all co-pays, deductibles and percentages required by my insurance plan.

I understand that I will be billed for "After-Hours Telephone Contacts" and for "Missed Appointments" as follows:
$40.00 Fee for After-Hours Patient Initiated Telephone Management of Medical Problems.

$25.00 Fee for Missed Appointments and No Shows (less than 24 hours notice of cancellation)

$20.00 Fee for administration costs for co-pays not paid at time of service.

Patients requesting reports and/or results to be faxed, copied or mailed will be charged a yearly administration fee of $40.00.

When canceling an appointment on the weekend or after hours please leave your name and the date and time of the appointment you are canceling with our answering service which takes calls 24 hours a day, 7 days a week.

No prescriptions will be faxed. No referrals will be faxed.

Forty-eight (48) notice is required for all referrals. Patient is responsible for providing this office with the specialists name, telephone number and identification number.

I assume responsibility for providing complete billing information to any specialist, laboratory and/or radiology facility that I am referred to in relation to my office visit. I understand that if I am referred to a specialist, laboratory and/or radiology facility I am responsible to verify that they are participating with my insurance network. I will also be responsible for obtaining all insurance referrals for specialist.

If you have questions regarding this information please feel free to discuss them with the office staff.

I acknowledge receipt of this letter.

_____	_____	_____
PATIENT SIGNATURE	PATIENT NAME (PRINT)	DATE

PATIENT HIPAA AWARENESS

With my permission, Dr Zoovia Hamiduddin, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Zoovia Hamiduddin's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have reviewed the Notice of Privacy Practices prior to signing this consent. Dr. Zoovia Hamiduddin reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Zoovia Hamiduddin may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Zoovia Hamiduddin may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder card and patient statements as long as the are marked Personal and or Confidential.

With my permission, the office of Dr. Zoovia Hamiduddin may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Zoovia Hamiduddin restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Hamiduddin to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient of Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

COVID QUESTIONS

PATIENT NAME _____

DATE OF BIRTH_____

PHONE NUMBER_____

TODAYS DATE_____

*cell phone _____

*email address _____

IN THE PAST 14 DAYS ...	Yes	No
1. Have you experienced fever?	___	___
2. Have you experienced a recent onset of respiratory problems such cough or shortness of breath?	___	___
3. Have you traveled to a country reported to be infected according to the World Health Organization with documented 2019-nCoV transmission?	___	___
4. Have you come into contact with any person with confirmed 2019-nCov infection?	___	___
5. Are there at least two people with documented experience of fever or respiratory problems that have been on contact with you?	___	___
6. Have you recently participated in any gathering, meeting or had close contact with unacquainted persons?	___	___

Signature _____

*I consent to calls and emails in regards to appointments & medical information.