Access Family Care, LLC
Tazeen Zaidi, MD — Family Medicine

712 W 25th St, Sanford, FL 32771
Phone (407) 402-2303 • Fax (407) 322-6341
accessfamilycarefl@gmail.com

New Patient Registration Form

Please complete all sections. Bring a valid photo ID and current insurance card(s) to your appointment.

Please Note: Please print this completed form and bring it to your appointment. Do not return this form by email or upload it online.

PATIENT INFORMATION

Last Name *

First Name *

Middle Initial

Sex

Preferred Name

Date of Birth *

Social Security Number (optional)

Marital Status

Home Address *

Apt/Unit

City *

State *

ZIP *

County

Cell Phone *

Home Phone

Email Address

Preferred Method of Contact (phone, text, email, portal)

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BIOGRAPHY

Race/Ethnicity questions below comply with OMB Standards for Maintaining, Collecting, and Presenting Data for Race and Ethnicity. Please select the category or categories that best describe your background.

Ethnicity (mark one):

- ☐ Hispanic or Latino
- ☐ NOT Hispanic or Latino
- ☐ Decline to State

Race (mark as many as apply):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Decline to State

Other Race (if not listed above)

Language (mark primary language):

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Hindi/Urdu
- ☐ Arabic
- ☐ Other

Other Language (if selected above)

Sexual Orientation:

- ☐ Straight, Heterosexual
- ☐ Lesbian, Gay, Homosexual
- ☐ Bisexual
- ☐ Something Else
- ☐ Do Not Know
- ☐ Choose Not to Disclose

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Female to Male (FTM), Transgender Male
- ☐ Male to Female (MTF), Transgender Female
- ☐ Genderqueer, Neither Exclusively Male or Female
- ☐ Choose Not to Disclose

Other / Please Specify (Sexual Orientation or Gender Identity)

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EMPLOYMENT

Employment Status | Employer Name | Employer Phone

EMERGENCY CONTACT

Full Name * | Relationship to Patient * | Phone Number *

Mailing Address

PRIMARY CARE / REFERRAL

Referring Physician (if any) | Pharmacy Name

Pharmacy Address / Cross Streets | Pharmacy Phone

Preferred Lab (e.g., Quest, LabCorp)

INSURANCE INFORMATION — PRIMARY

Insurance Company Name | Plan Type (HMO/PPO/Medicare/Medicaid)

Member/Policy ID Number | Group Number | Effective Date

Subscriber (Policyholder) Name | Subscriber DOB | Relationship to Patient

INSURANCE INFORMATION — SECONDARY (IF APPLICABLE)

Insurance Company Name | Plan Type

Member/Policy ID Number | Group Number | Effective Date

Subscriber (Policyholder) Name | Subscriber DOB | Relationship to Patient

INSURANCE AUTHORIZATION CONSENT

Patient Name (Last, First) | Date of Birth

Primary Insurance | Insured's Name

Relationship | DOB | Secondary Insurance

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I hereby authorize my insurance benefits to be paid directly to Access Family Care, LLC and authorize my physician to release any information requested by my insurance carrier.

Signature

Date

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PATIENT CONTACT PREFERENCES / RELEASE OF PATIENT INFORMATION

People whom we may share information regarding your care:

Name	Relationship	Contact Number

I hereby grant permission to Access Family Care, LLC to share information regarding my care to the people listed above.

Signature

Date

CONSENT TO TREATMENT

I voluntarily consent to medical examination and treatment by Tazeen Zaidi, MD, and other clinical staff of Access Family Care, LLC. I understand that no guarantee has been made regarding the outcome of examination or treatment.

☐ I consent to treatment as described above

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AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Access Family Care, LLC any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare and all other insurance benefits be made on my behalf to Access Family Care, LLC for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

If my insurance has a contract with Access Family Care, LLC, I am not responsible for amounts it has agreed to write-off. If my insurance does not have a contract with Access Family Care, LLC, I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default. If balance of payment needs to be forwarded to a collection agency, I understand that I will be dismissed from the practice.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Access Family Care, LLC.

I hereby acknowledge that I have received and reviewed the Financial Policies of Access Family Care, LLC.

Signature

Date

HOW DID YOU HEAR ABOUT US? (OPTIONAL)

- ☐ Internet
- ☐ Insurance Website
- ☐ Dr. Reference
- ☐ Another Patient

If Dr. Reference or Another Patient, Please Specify Name

PATIENT / GUARDIAN SIGNATURE

Printed Name *

Date *

Signature *

Date *

Relationship to Patient (if signing for a minor/dependent)