



## Syed F. Hussain M.D. Patient Registration Forms

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Preferred Method of Contact (Circle One) Email, Home Phone, Cell Phone, Work Phone

Would you like to receive reminder text messages? (Circle One) Yes No

Birth Sex: Male \_\_\_\_ Female \_\_\_\_ Gender Identity: Male \_\_\_\_ Female \_\_\_\_

Sexual Orientation: (Circle One) Straight, Bisexual, Lesbian or Gay, Choose not to disclose

Marital Status: (Circle One) Single, Married, Divorced, Domestic Partner, Widow(er)

Race: (Circle One) White, Black, Hispanic, Native American/Alaskan Native, Bi-Racial

Other \_\_\_\_\_

Ethnicity: Circle One: Hispanic/Latino, Not Hispanic/Latino

Dominant Hand: (Circle One) Left, Right, Ambidextrous

Language Preference \_\_\_\_\_

Do you require a translator? YES or NO



**Primary Insured Information**

Insurance Company \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_

Guarantor Name \_\_\_\_\_ Relationship \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_

**Secondary Insured Information**

Insurance Company \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group# \_\_\_\_\_

Guarantor Name \_\_\_\_\_ Relationship \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Effective Date \_\_\_/\_\_\_/\_\_\_

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to Health First Medical Center and I understand that I am financially responsible for charges for medical services rendered to the above named patient regardless of insurance coverage, including amount not limited to any and all immunizations. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due.

Patient or Guarantor Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Diagnosis History:**

Diagnosis	SELF	MOTHER	FATHER	DAUGHTER	SON	SIBLING	GRANDPARENT
ANEMIA							
ANXIETY							
ARTHRITIS							
ASTHMA OR COPD							
BIRTH DEFECTS							
BLINDNESS							
BLOOD CLOTS							
CANCER TYPE: _____ IN REMISSION? Y/N							
DEPRESSION							
DIABETES							
FATIGUE							
GALLBLADDER DISEASE							
HEADACHES							
HEART DISEASE							
HEPATITIS TYPE: _____ IN REMISSION? Y/N							
HIGH CHOLESTEROL							
HIV/AIDS							
HYPERTENSION							
INSOMNIA							

Diagnosis	SELF	MOTHER	FATHER	DAUGHTER	SON	SIBLING	GRANDPARENT
KIDNEY DISEASE							
LIVER DISEASE							
MENTAL ILLNESS TYPE:							
MUSCULOSKELETAL PAIN LOCATION:							
OSTEOPOROSIS							
PROSTATE ISSUES (BPH)							
STROKE							
THYROID PROBLEMS HYPOTHYROID Y/N HYPERTHYROID Y/N HASHIMOTO'S Y/N THYROID NODULE Y/N GOITER Y/N							
TUBERCULOSIS							
VISION ISSUES TYPE:							
WEIGHT GAIN							
WEIGHT LOSS							

**Other Medical Conditions:**

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**Surgical History**

<b><u>SURGERY TYPE</u></b>	<b><u>DATE</u></b>

**Screening Tests**

<b><u>TEST</u></b>	<b><u>DATE</u></b>	<b><u>RESULT</u></b>
PAP SMEAR		
BREAST EXAM		
MAMMOGRAM		
PROSTATE EXAM		
PSA		
COLONOSCOPY		
STOOL STUDY FOR BLOOD		
DEXA SCAN		
EKG		

**Social History**

**Tobacco use:** Yes \_\_\_\_\_ No \_\_\_\_\_ Quit? \_\_\_\_\_ When? \_\_\_\_\_

**Current illicit drug use:** Yes \_\_\_\_\_ No \_\_\_\_\_ Type? \_\_\_\_\_

**Past illicit drug use:** Yes \_\_\_\_\_ No \_\_\_\_\_ Type? \_\_\_\_\_

**Alcohol use:** Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_

**Do you exercise regularly?** Yes \_\_\_\_\_ No \_\_\_\_\_ How Often? \_\_\_\_\_

**Do you have a living will or advanced directive?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Local Pharmacy Information:**

**Patient Name:** \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

**Address or Cross Streets:** \_\_\_\_\_

**Pharmacy Phone Number:** \_\_\_\_\_

**Mail Order Pharmacy**

**Pharmacy name:** \_\_\_\_\_

**Do you prefer 30 day or 90 day prescriptions? Circle one**

I authorize my pharmacy to provide my medication list and history to Health First Medical Center.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**Acknowledgement of Privacy Practice Notice 2003**

I hereby acknowledge that **I have received a copy of the Privacy Practices Notice**, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print name: \_\_\_\_\_

\_\_\_\_\_

On this date I was offered, but **declined a copy of the Privacy Practices Notice**. I am aware that a copy of the privacy practice notice is available to me at my request at a later date, should I request it.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print name: \_\_\_\_\_



# HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information  
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

I authorize \_\_\_\_\_ (previous healthcare provider or specialist) to use and disclose the protected health information described below to:

Syed F. Hussain MD  
1641 E Flamingo Road #10  
Las Vegas, NV 89119  
Fax: 702-369-8057

Effective Period - This authorization for release of information covers the period of healthcare from:  \_\_\_\_\_ to \_\_\_\_\_ OR  all past, present, and future periods.

### Extent of Authorization

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): \_\_\_\_\_

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until \_\_\_\_/\_\_\_\_/\_\_\_\_ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the an insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Printed name of patient or personal representative and his or her relationship to patient  
\_\_\_\_/\_\_\_\_/\_\_\_\_



## Narcotics Contract/Policies 2026

New patients requesting continuation of narcotic pain medication, muscle relaxants, or anti-anxiety medications, stimulants or other controlled medication will require previous medical records to evaluate the need for continuation of that medication.

Health First Medical Center will run regular DEA reports, toxicology and drug testing to confirm the use and compliance of said medications. This office requires that patients using narcotic pain and anxiety medication will need periodic laboratory testing to ensure the medication is not having a negative effect on your organs.

**All new and re-establishing patients are subject to baseline drug monitoring at their initial appointments.**

In addition to laboratory and diagnostic testing, the doctor may refer you to psychiatry, physical therapy, orthopedics and/ or pain management. Patients not following the physician's orders or failing to comply by not completing any diagnostic testing, physical therapy or any other referrals ordered by the doctor will not be prescribed any more of these medications.

**Under no circumstances will duplicate prescriptions be dispensed. Be sure to keep all your medications in a safe location, away from children. Women of childbearing age and women who are pregnant should be aware that damage to the fetus is possible when using a controlled substance. Please notify us if you are pregnant or become pregnant immediately. Please be advised that by signing this document, you acknowledge that you understand these policies. You acknowledge that the provider has discussed the risks and benefits of the medication. You acknowledge that Health First Medical Center, Dr. Syed Hussain, and the rest of the staff are not responsible for any injury or death due to the abuse of the controlled or narcotic medication. In the event that narcotics are abused or misused or there is deviation from the plan, the patient will be immediately discharged from the practice.**

\_\_\_\_\_  
Patient name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



## **Practice Policies**

1. A **\$40 fee** will be added to your account in the event of a no show/cancellation. Our office requires **48 hour** advance notice for canceled appointments. **This fee is not covered by insurance and is the responsibility of the patient/guarantor.**  
\_\_\_\_\_ (Initial here)
2. **All copays are due at the time of your visit**, unless previous arrangements have been made. \_\_\_\_\_ (Initial here)

### **Medication Refill Policy**

1. There is a **72 business hour turnaround time for medication refills**, please allow yourself time and contact the pharmacy a few days in advance to ensure you do not run out of your medications. **You may require an office visit for certain refills or if you haven't had a follow up within the requested time frame.** \_\_\_\_\_ (Initial here)
2. Certain medications such as narcotics and antibiotics may require an office visit prior to refill. **Failure to keep your appointment may delay timely refills if applicable.**  
\_\_\_\_\_ (Initial here)

### **Collection/Return Check Policy**

1. Patients who have been sent to collections are required to either resolve their balance or make proper arrangements with our billing office or collection agency prior to being seen. \_\_\_\_\_ (Initial here)
2. By signing this document I hereby agree to all the financial responsibility for all charges incurred regardless of insurance coverage. In the event my account is referred to a collect service due to lack of payment on my part, I agree to pay all collection/legal fees that will be added. Returned Checks: A \$40 NSF fee will be charged for a check initially returned unpaid by your bank, if the same check is returned unpaid a second time an additional \$40 NSF fee may be added. \_\_\_\_\_ (Initial here)

\_\_\_\_\_  
Patient name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or responsible party Signature



## 2026 PATIENT CODE OF CONDUCT

**The prevalence of workplace violence in health care remains higher than most professions. According to the Occupational Safety and Health Administration (OSHA), approximately 75 percent of nearly 25,000 workplace assaults reported annually in health care and social service settings.**

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, Fa Health First Medical Center expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited:

- Possession of firearms or any weapon
- Physical assault, arson or inflicting bodily harm
- Throwing objects, stealing supplies, decorations, other office property, etc.
- Intoxication due to alcohol or illicit drugs.
- Making verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Making menacing gestures, inappropriate touching of the staff, patients, or visitors
- Attempting to intimidate or harass other individuals
- Making harassing, offensive or intimidating statements (aggressive speech or profanity), or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. **By signing below you acknowledge these policies and agree to abide by them. Violators are subject to removal from the facility and/or discharge from the practice.**

\*Adults are expected to supervise children in their care.

Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_



**Emergency Contact Information**

\* In the event of an emergency or if we are unable to contact you, we will contact the below listed individual(s) to attempt to make contact with you.

**Patient Name** \_\_\_\_\_

**DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient's Relationship to Contact** \_\_\_\_\_

**First Name** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_

**Work Phone** \_\_\_\_\_

**Home Phone** \_\_\_\_\_

If you have multiple contacts you wish to add, please list them below or request an additional form.

