MAZHAR MAJID, M.D.
Clinical, Invasive & Interventional Cardiology

MEDICATIONS LIST

Patients Name: _____

DOB: _____

MEDICATION	**DOSAGE**

MAZHAR MAJID, M.D.

Clinical, Invasive & Interventional Cardiology

Diplomat American Board of Internal Medicine
Diplomat American Board of Cardiovascular Diseases

Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. MAZHAR MAJID, MD HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Dated this_____day of _____20____

_____
Patient Signature

_____
Print Patient Name

77371N. University Drive Suite 104
Tamarac, FL 33321
Tel: 954-720-1930 Fax: 954-720-6130

MAZHAR MAJID, M.D.

Clinical, Invasive & Interventional Cardiology

Diplomat American Board of Internal Medicine
Diplomat American Board of Cardiovascular Diseases

If you would like for appointment confirmations to be emailed and texted to you please provide your email address and cell phone number.

Email Address _____
PLEASE PRINT

Cell Number: _____
PLEASE PRINT

By providing us with this information you will have access to the Patient Portal to view your records, make appointments and much more.

_____ By initialing here you choose to decline this service

Sign _____ Date _____

7737 N. University Drive Suite 104 Tamarac FL. 33321
Tel: 954-720-1930 Fax: 954-720-6130

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Living Will

Your Right to Decide and Make Your Wishes Known

Declaration made this _____day of_, Year_____.

I,_____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below and I do hereby declare that, if at any time I am mentally or physically incapacitated.

_____ (Initial) and I have a terminal condition
Or _____(Initial) and I have an end-state condition
Or_____(Initial) and I am in a persistent vegetative state

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally With only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event I have been determined to be unable to provide express and informed consent regarding the withholding withdrawal, or continuation of life-prolonging procedures, I wish to designate as my surrogate to carry out the provisions of this declaration:

Name:_____
Address: _____
Zip Code _____Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____

_____

(Signed)_____
(Witness)_____
(Address)_____
(Witness)_____
(Address)_____

QIC Approved September 2003

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DESIGNATION OF HEALTH CARE SURROGATE

Name: _____
(Last) **(First)** **(Middle Initial)**

In the event that I have been determined to be incapacitated to provide informed consent for medical Treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____
Address: _____
City:_____**State:**_____**Zip:**_____
Telephone Number(_____**)**

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____
Address: _____
City:_____ **State:**_____**Zip:** _____
Telephone Number: **(**_____**)**

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw my consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional):_____ _____

_____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I will notify and send a copy of this document to, the following persons other that my surrogate, so they may know who my surrogate is.

Name: _____
Name: _____
Name: _____

Dated this _____ **day of** _____ **20**____

_____

Print Name: _____

Witness:

_____ _____
Print Name:_____ **Print Name:**_____
Address:_____ **Address:**_____
_____ _____
Phone: (_____**)**_____ **Phone: (**_____**)**_____

(At least one witness must be neither a spouse nor a blood relative of this signatory)

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Patient's Name: _____ **Birthdate:** _____ ❑ **Age:** _____

❑ SINGLE ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED SEX_____

M A R R I E D

Horn A

Patient or Responsible Parent Employed By: _____

Business Address: _____ C i t y : _____

O c c u p a t i o n : _____ Business Phone: _____

Name of Spouse: _____ Occupation: _____

Business Address: _____ C i t y : _____

Spouse Employed By: _____ Business Phone: _____

Referred By: _____ Physician: _____

Primary Physician: _____ Patient's S.S.#: _____

Medical Insurance Plan: _____ Insured's S.S.#: _____

Insurance Policy Number: _____ Drivers License #: _____

If Patient is a Minor, Name of Responsible Parent: _____

All fees are due the day services/surgery are rendered. If you have medical insurance, we will be happy to complete your insurance claim form on paid accounts. The insurance company will then reimburse you.

MEDICAL HISTORY

Answers to the following questions are for our records and are considered confidential.

1. Are you in good health? 1) YES ❑ NO ❑
2. Date of last physical exam: _____
3. Are you or have you been under a physician's care during the last 5 years? 3) YES ❑ NO ❑
4. Have you ever had any serious illness, operation or hospitalization? 4) YES ❑ NO ❑
5. Circle any of the following which you have or have had:

Fainting Dizziness *Nervous Disorders* Rheumatic Fever Congenital Heart Defect TB Heart Murmur Heart Trouble/AttaCk

Angina/Chest Pain Respiratory Problems Pacemaker Heart Valve Problems Low /High Blood Pressure Diabetes

Hepatitus Stomach Ulcers Liver Disease Allergies Epilepsy Lung Disease Coughing Up Blood

Shortness of Breath Asthma Convulsions Glaucoma Anemia Kidney Disease Thyroid Disease Cancer

Blood Disorders Stroke Venereal Disease Hip or Bone Implants Swolen Ankles Mental Health Disease

6. Have you ever had any unusual reaction or allergy to an anesthetic, drug, latex, soy products, milk or eggs? 6) YES ❑ NO ❑
7. Are you allergic to Penicillin? 7) YES ❑ NO ❑
8. Are you taking ANY medications, Vitamins and/or Herbal Supplements Now? 8) YES ❑ NO ❑

   If YES, what? _____
9. Have you ever taken prescription medication for weight reduction (DIET PILLS). 9) YES ❑ NO ❑

   If "YES", did you take any of these listed drugs? (Please check all that apply)

   ❑ Fen-Phen (fenfluramine + phentermine) ❑ Pondimin (fenfluramine) ❑ Redux (dexfenfluramine)
10. If you have ever taken any of the above listed drugs, have you ever had a medical exam to ensure that your heart valves were not affected? 10) YES ❑ NO ❑
11. Do you take aspirin daily? 11) YES ❑ NO ❑
12. Do you have any history of prolonged bleeding following an operation or accident or history of blood transfusion? 12) YES ❑ NO ❑
13. Have you taken any cortisone or steroids during the last year? 13) YES ❑ NO ❑
14. Are you pregnant or possibly pregnant? 14) YES ❑ NO ❑
15. Are you taking birth control pills or hormones? 15) YES ❑ NO ❑

    I am aware of *interaction* between Antibiotics and Birth Control Pills. *Signature _____
16. Do you have any disease, condition or problem not listed above that we should be aware of? 16) YES ❑ NO ❑

    If YES, please explain: _____
17. Is there anything you would like to discuss privately with the doctor? 17) YES ❑ NO ❑
18. Do you smoke? ____ Do you chew tobacco? ____ (Please check all that apply)
19. Reason for visit? _____
20. Dr. Majid and his staff may discuss my medical history and or case and my financial arrangements and responsibilities with the following person(s): _____

21, Dr. Majid and his staff may leave a voice message or speak with the person who answers my phone when calling to confirm an office appointment.

* Signature of Patient: _____ Date: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Majid or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

* Signature of Patient: _____ Date: _____

CONSENT FOR EXAMINATION/TREATMENT

This is to certify that I, the undersigned, hereby authorize Dr. Majid and assistants to perform whatever examination or treatment deemed necessary. The medical history I have given is correct. I acknowledge that no guarantee or assurance has been made to me as to the reults of the examination or treatment.

On rare occasions, some unusual, unexpected and severe reactions or complications can occur, but I feel it would be impractical and misleading to describe in detail all those that would arise during or following examination or treatment. If you have further questions, please feel free to ask me before the procedure has begun.

S i g n a t u r e o f P a t i e n t : D a t e : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I HAVE RECEIVED, READ AND UNDERSTAND COMPLETELY THE HIPPA "NOTICE OF PRIVACY PRACTICE"

* Signature: _____ Date: _____

Pre-Op Instructions Given: _____ Post-Op instructions given: _____

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NO SHOW POLICY

I _____understand that there will be a $25.00 NO SHOW FEE that I am fully responsible for if I do not call or cancel my appointment for any Office Visit or PROCEDURES being done in the office (excluding the Stress Test) at least 24 hours in advance.

_____
Patient's Signature

_____
Printed Name

_____
Date

Mazhar Majid, MD, F.A.C.C, F.A.C.P., F.S.C.A.I., M.A.A.C.
Tax Id: 81-0558637 NPI: 1821378712