Faisal Bahadur, MD
Gautam Kedia, MD
Bashar Markabawi, MD, FACC

Patient's Name (Last) _____ (First) _____ (M.I.) _____

SS# _____ Date of Birth _____/_____/_____ Marital Status _____ Sex _____

Race :(optional) _____ Ethnicity: (optional) _____ Preferred language: _____

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone #: _____

Local Address	**Permanent/Mailing Address**
Street _____ Apt#_____	Street _____ Apt# _____
City, State, Zip _____	City, State. Zip _____
Phone (H) _____ (B) _____	Phone (H) _____ (B) _____

Cell Phone _____ **Email address** _____

Would you like to register for web portal? _____Yes _____No

Emergency Contact

Name (Last) _____ (First) _____ (M.I.) _____

Phone (H) _____ (B) _____ Relationship to Patient _____

I have read and acknowledge all of the above policies associated with Lifetime Heart & Vascular including:
(PLEASE INITIAL)

_____Authorization to Release Medical Records

_____Financial Policy

_____Acknowledgement of Privacy Practices and Advanced Directives

_____Privacy Notice Acknowledgement and Communication Consent

_____Appointment Cancellation and No Show Policy

_____ _____

Patient Signature/ Parent / Legally Authorized **Date**

Patient/Parent/Legally Authorized Printed Name_____