New Patient Packet

Dr. Gohar S. Khan MD

Last updated: 2013

Registration Options:

1. Mail this back to us at:
    - Dr. Gohar S. Khan MD
    - ATTN: New Patient Packet
        - 905 Beville Rd.
        - South Daytona, FL 32119
2. Fax this back to us at: (386)767-3761
3. Email this back to us at: DrKhan905@gmail.com
4. Drop this off at the office between the hours of 9:00am – 3:00pm Monday-Thursday

Patient Registration Form

Patient Information

Title Name:		First:	Middle:	Last:	
Address:		City:	State:	Zip Code:	
Age:	Race:	Sex(circle one): Male Female	Spouse's Name:	Marital Status:	
Patient Employer:		Occupation:	Work Address:	City:	
				State:	Zip Code:

Responsible Party

First Name:	Middle:	Last:	
Address:	City:	State:	Zip Code:
Home #:	Work #:	SS #:	
Employer(work):	Address:	City:	
		State:	
		Zip:	

Insurance Information

Primary Insurance Company:	Phone #:	
	City:	
Address:	State:	Zip Code:
Insured's Name:	Group #:	
I.D #:	Birth date:	
Secondary Insurance:	Phone #:	
	City:	
Address:	State:	Zip Code:
Insured's Name:	Group #:	
I.D. #:	Birth date:	

Is this visit a result of a work injury? Yes No	Date Injured:	Industrial Claim #:
Is this visit a result of a car accident? Yes No	Date Of Accident:	
	Attorney Name:	
How long Employed at current Position?	Who can we thank for referring you to us?	
Drug Allergies (list):	Other:	

HISTORY & PHYSICAL

Name:_______________________________ **SS#**________________________ **Date**_____________________
Address:____ **City:**_______________________ **State:**__________
Occupation:_________________________ **Home #:**__________________ **Work #:**__________________
Birthdate:_________________ **Age:**_____ **Chief Complaint:**____

Drug Allergies:	**Current Medications:**
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Family History:

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy / Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATION OR SURGERY

Date/Reason:______________________________	Date/Reason:______________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

HISTORY & PHYSICAL CONTINUED....

Medical History:

☐ Headache	Lactose Intolerance	Depression
☐ Shortness of Breath	Gallbladder Disease	Gout
☐ Heart Palpitations	Prostate Disease	Scarlet Fever
☐ Heart Murmur	Bowel Irregularity	Chronic Rashes
☐ Chest Pain	Incontinence	Rheumatic Fever
☐ Dizziness/Fainting	Sexual/Menstrual Dysfunction	Mumps
☐ Peripheral Vascular Disease	Venereal Disease	Measles
☐ Allergies/Hay Fever	Frequent Infections	Rubella
☐ Asthma	Hepatitis	Polio
☐ Bronchitis	Anemia	Diphtheria
☐ Pneumonia	Arthritis	Tetanus
☐ Ulcer	Osteoporosis	Other
☐ GI Disorder	Nervousness	Other

WOMEN ONLY: Pregnant? ☐ Yes ☐ No ⬌ Planning Pregnancy? ☐ Yes ☐ No

MEN ONLY: It's common for men to occasionally experience erection difficulties. Is this something that happens to you? ☐ Yes ☐ No

How often does this occur? ☐ Frequently ☐ Sometimes ☐ Rarely

HABITS:

☐ Smoke:
- Packs Daily:__________
- How Long:___________
- Interested in stopping:_______

☐ Exercise Routine:________________________________
____
____
____

☐ Coffee:
- Cups Daily:_______
- Other Caffeine:________________

☐ Alcohol:
Type:___________________
Amount:_________________

☐ Diet:
- Salt Intake:___________________
- Fat Intake:___________________

☐ Sleep:
- Difficulty falling asleep:____________
- Continuity Disturbances:_____________
- Snoring:__________
- Early morning awakening:___________
- Daytime drowsiness:_________________
- Other:_______________________________

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Name:____ Date:_______________________

Has your address, phone number, or INSURANCE changed? If so, please provide us with your current information and present your insurance card at each visit. THANK YOU.

Current Phone #:_______________________

Email Address:___________________________@_______________________

- **What are you being see for today?**

- **Have you had any recent accidents or injuries? If so, what type and on what date?**

- **Do you need any MEDICATION REFILLS today? If so, what prescriptions?**

- **What is your local pharmacy?**

Note: Please be advised that PRESCRIPTIO REFILLS are only given at time of APPOINTMENTS. Please do not wait until prescriptions are completely out.

There will be a $25.00 charge for all appointments that are not cancelled or rescheduled within 24 hours of the scheduled appointment.

Patient Signature:____

Dr. Gohar Khan, M.D.
905 Beville Rd.
South Daytona, FL 32119

DON'T LOSE YOUR RIGHT TO DECIDE!!

You cannot remove all uncertainty about your future healthcare needs but by having an advanced directive you can have the peace of mind that comes from making your wishes known in advance!

Declaration to Decline Life-Prolonging Procedures (Living Will)

- ☐ 〉 I have made a Living Will
- ☐ 〉 I do not have a Living Will

Health Care Surrogate

- ☐ 〉 I have designated a Health Care Surrogate
- ☐ 〉 I have NOT designated a Health Care Surrogate

Durable Power of Attorney

- ☐ 〉 I have appointed a Durable Power of Attorney for Health Care decisions
- ☐ 〉 I have NOT appointed a Durable Power of Attorney

Print Name:___________________________________

Signature:____________________________________

Date:____

Dr. Gohar Khan, M.D.
905 Beville Rd.
South Daytona, FL 32119

OFFICE PAYMENT POLICY

WE ARE HAPPY TO FILE YOUR INSURANCE CLAIMS FOR OUR SERVICES, PLEASE MAKE SURE WE HAVE ALL OF YOUR INSURANCE INFORMATION. AFTER 60 DAYS ANY BALANCE STILL OUTSTANDING ON YOUR ACCOUNT, REGARDLESS OF ANY INSURANCE CLAIM, BECOMES YOUR RESPONSIBILITY AND WE EXPECT PAYMENT IN FULL AT THAT TIME. IF YOU ARE UNABLE TO PAY YOUR OUTSTANDING BALANCE IN FULL AT THAT TIME, PLEASE CALL US TO ARRANGE MONTHLY PAYMENTS. YOU WILL BE ASKED TO SIGN A PROMISE OF PAYMENT AT THAT TIME.

THANK YOU,

DR.KHAN

THE ABOVE POLICY HAS BEEN EXPLAINED TO ME. I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATLEY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT AFTER 60 DAYS.

SIGNATURE:____

DATE:___________________________________

Dr. Gohar Khan, M.D.
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IMPORTANT NOTICE
PLEASE READ

I feel as your health care provider, your health management is as much your responsibility as it is mine. For this reason, I am asking you to be sure that a follow-up appointment is made after any diagnostic testing is done. This includes blood-work, x-ray, ultrasounds, etc. The reason for this is to be able to speak with you, one on one, to be sure that you understand the results, and what they mean. This also gives you the opportunity to have me answer any questions or concerns that you may have about the results of these tests. I want to be sure that you, the patient, fully understand your test results. There are times that further testing is indicated and such testing can be arranged at this time. I appreciate your cooperation and wish to continue giving you excellent health care as your physician.

Thank You,

Dr. Gohar S. Khan, M.D.

Patient Signature: ________________________________

Date: ________________

905 Beville Rd.
South Daytona, FL 32119

Patient Name:____________________________________ Date of Birth:___________________
(Last) (First) (MI)

Medical Record Number:____________________________ Signature:________________________

I hereby authorize:	**To Release Information to:**
Name of facility:__________________________	Individual Name:__________________________
Address of releasing facility:________________	Facility/Organization and Address:____________

☐ Including attached addendum

☐ Date & Time of Appointment:____

PURPOSE OF DISCLOSURE:

- ☐ Continuing Care
- ☐ Payment of Claim
- ☐ School
- ☐ Worker's Compensation
- ☐ Legal
- ☐ For Personal Use
- ☐ Other (specify):____

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by initialing below:
_________Do not release Alcohol and/or Drug Abuse Information
_________Do not release Behavioral Health Information

INFORMATION TO BE RELEASED: Between Dates of:_______________to___________________

☐ Discharge Summary	X-Ray Reports	Psychiatric Testing
☐ H&P Exam/Initial Evaluation	X-Ray Films/MRI	Transfer/Outside Information
☐ Consult	Diagnostic Test Reports	Completed Form
☐ CD Counselor/Therapist Reports	Procedure Reports	Exchange of Verbal Communication
☐ Progress Notes/Provider Notes	Lab Reports/Pathology	HIV related information
☐ Orders	Correspondence	AIDS related testing
Other (Specify content & dates:______________________________________		

Gohar S. Khan, M.D P.A
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ACKNOWLEDGMENT OF UNDERSTANDING

- I understand the expiration date of this authorization is ____________ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing; and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this content for release of alcohol and/or drug abuse information is subject to revocation at anytime except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it.
- I understand that SMDC may not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with MN Statute 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand photocopy or fax of this form is the same as the original
- I understand that (1) my HIV test results may be released without my authorization to persons / organizations that have access under Wisconsin law; and that (2) a list of those persons / organizations is available upon request.

Sign:____
(Signature of patient, parent of minor, or personal representative)

Relationship:_____________________________

Date:____________________________

Gohar S. Khan MD
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HIPAA CONCENT

I hereby authorize my physician to release the health information I have entered while filling out this packet. The health-related materials may include information related to treatments and therapies specific to the healthcare entity. Dr. Gohar S. Khan's office will safeguard my personal information and will not use it for any purpose other than to provide health-related materials to me, anonymously analyze health outcomes in support of educational health content, as well as to measure the effect of the health-related materials furnished to me with mine or my family member's physician.

While there is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected by federal privacy rules, this office maintains administrative, technical and physical safe-guards as required by the Federal Government's Health Information Privacy Rule "HIPAA", to protect each patient's confidential information.

I do not have to grant this Authorization, but if I do not, I will not receive personalized health-related material. I understand that my physician will treat me regardless of whether I grant this Authorization or not.

I may change my mind and revoke (take back) this Authorization at any time, except to the extent that my Physician has already acted based on this Authorization. To revoke this Authorization I will have to speak to the Physician.

Sign:________________________________

Name:__________________________________

Date:________________________