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

Date of Appointment:

Patient Information

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)	
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address		City	State	Zip	
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone	Pharmacy Address			

Patient Employer/School Information

Employer/School	Occupation	Employer/School Phone	
Employer/School Address	City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number
Insured's Address		City	State / Zip
Insured's Social Security Number	Insured's Birthdate		

Secondary Health Insurance

Insurance Company		Plan	
Plan Number	Group Number	Insured's Employer/School	Insured's Social Security Number
Insured's Name (as it appears on insurance card or ID)		Relation to Patient	Insured's Phone Number

Responsible Party

Billing Name (if other than patient)	Phone	Relation to Patient	
Address	City	State	Zip

Signature of Patient or Authorized Guardian

Date

Name Gender Age

Date of Appointment:

Reason for Visit

What brings you to the office today?

How is your general health?

Excellent Good Fair Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

Adhesive Tape	Antibiotics	Latex
Barbiturates (Sleeping Pills)	Aspirin	Iodine
Codeine	Sulfa	Local Anesthetics

Do you have any other allergies?

Name	Reaction
Name	Reaction

Past Medical History

Alcoholism	Back Problems	Ear Problems	Hepatitis - A, B, or C	Measles	Skin Disorder
Allergies	Bleeding Disorder	Eating Disorder	High Blood Pressure	Migraines	Stomach Ulcer
Anemia	Blood Disease	Epilepsy	High Cholesterol	Osteoporosis	Substance Abuse
Anxiety Disorder	Blood Transfusion	Glaucoma	Joint Disorder	Pneumonia	Thyroid Disorder
Arthritis	Cancer	Gout	Kidney Disorder	Polio	Tuberculosis
Asthma	Diabetes	Heart Disease	Liver Disorder	Rheumatic Fever	Venereal Disease
AIDS / HIV	Depression	Heart Problems	Lung Disease	Stroke	

Hospitalizations & Surgeries

Reason	Date
Reason	Date

Women Only:

of Pregnancies # of Miscarraiges # of Abortions # of Living

Last Pap Smear Last Mammogram Birth Control Method

Family History

Has anyone in your family ever had any of the following conditions?

Alcoholism	Cancer	Joint Disorder
Allergies	Depression	Kidney Disease
Alzheimer's	Diabetes	Liver Disorder
Anemia	Epilepsy	Lung Disease
Anxiety	Genetic Disorder	Migraines
Arthritis	Glaucoma	Psychiatric Disorders
Asthma	Heart Disease	Osteoporosis
AIDS/HIV	Hepatitis	Stroke
Bleeding Disorder	High Cholesterol	Substance Abuse
Blood Disorder	High Blood Pressure	Thyroid Disorder

Details:

Lifestyle Factors

Are you sexually active?

Yes No # of partners in past year

Do you wish to be checked for STDs?

Yes No

Has anyone in your home ever physically or verbally hurt you?

Yes No

Have you ever smoked?

Yes No # of years # packs/day

Do you smoke now?

Yes No # packs/day

Do you use recreational drugs?

Yes No types? # times/week

How much alcohol do you drink per week?

drinks/week

How much caffeine do you drink per day?

drinks/day

How often do you exercise?

times/week

Name Gender Age Date of Appointment:

Review of Systems

General
- Chills
- Dizziness
- Fainting
- Fever
- Hair Loss
- Hair Growth – Excessive
- Night Sweats
- Sleeping Problems
- Thirst - Excessive
- Weight Gain
- Weight Loss

Mental Health
- Anxiety
- Depression
- Loss of Interest
- Feeling Hopeless
- Hearing Voices
- Marital Problems
- Panic Attacks
- Trouble Concentrating
- Suicide–Thoughts/Attempts

Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

ENT
- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earaches
- Ear Discharge
- Hay Fever
- Hoarseness
- Hearing Loss
- Nose-Bleeds
- Persistent Cough
- Persistent Runny Nose
- Recurring Sore Throat
- Ringing in Ears
- Sinus Problems
- Vision Halos

Respiratory
- Coughing
- Coughing Up Blood
- Shortness of Breath
- Wheezing

Cardiovascular
- Chest Pains
- Irregular Heart Beat
- Circulation Problems
- Heart Palpitations
- Rapid Heartbeat
- Swelling of Ankles
- Varicose Veins

Musculoskeletal
- Back Pain
- Carpal Tunnel Syndrome
- Joint Pain
- Joint Swelling
- Neck Pain
- Shoulder Pain

Men Only
- Erection Difficulties
- Lump in Testicles
- Penile Discharge
- Sore on Penis

Women Only
- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge

Other Symptoms

_____

_____

_____

Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

	Month & Year		Month & Year
☐ Cholesterol Test	_____	☐ MRI	_____
☐ Colonoscopy	_____	☐ Physical Exam	_____
☐ CT/CAT Scan	_____	☐ Cardiac Stress Test	_____
☐ EKG		☐ Ultra Sound	
☐ Echocardiogram			

Immunizations

Please check and date all immunizations you have had.

	Month & Year		Month & Year
☐ Hepatitis A		☐ MMR (Measles, Mumps, Rubella)	
☐ Hepatitis B (Series of 3)		☐ Pneumonia	
☐ HPV Vaccine		☐ Polio	
☐ Influenza (Flu Shot)		☐ Tetanus	
☐ Meningitis			

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: ~~Gohar S. Khan, M.D., P.A.~~ ~~905 Beville Road~~ ~~So. Daytona, FL 32119~~
Address of releasing facility:_____	Facility/Organization and Address:_____ (386)767.9000 phone number (386)767.3761 Fax number

☐ 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:_____

905 Beville Rd
South Daytona , FL 32119

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:_____

Gohar S. Khan, M.D P.A
905 Beville Rd.
South Daytona, FL 32119

ACKNOWLEDGMENT OF UNDERSTANDING

- I understand the expiration date of this authorization is Valid while under the care of Dr. Gohar Khan 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:_____

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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: _____

Gohar S. Khan, M.D P.A

Gohar S. Khan MD
905 Beville Road
South Daytona, FL 32119

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:_____

The Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date of Visit:** _____

Practice Name: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself in some way.	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____