Patient Registration

PATIENT INFORMATION:

Last Name: _____First Name: _____
Middle Initial: ____
Mailing Address _____ City: _____ State: _____
Zip:_____
Phone Number: Home_____ Cell_____
Work _____
Date of Birth: _____ Gender: M F
Social Security #: _____ Marital Status: _____
Race: _____ Ethnicity: _____
Email address: _____

PATIENT EMPLOYER INFORMATION

Name of Company: _____
Phone Number: _____
Street Address: _____ City: _____
State: _____ Zip: _____

INSURANCE POLICY HOLDER INFORMATION

Primary

Insurance: _____ Subscriber ID#:
_____ Group#: _____
Last Name: _____ First Name:
_____ Middle Initial: ____
Date of Birth: _____ Gender: M F Social Security #:
_____ Marital Status: _____
Relationship to the Patient: _____

Secondary

Insurance: _____ Subscriber ID#:
_____ Group#: _____Last Name:
_____ First Name: _____
Middle Initial: ____Date of Birth: _____ Gender: M F
Social Security #: _____ Marital Status: _____

* Emergency Contact: _____
Phone #: _____

How did you hear about us (circle one):
family newspaper mail out / flyer television employee
internet drive by billboard / sign friend referring physician
walk in yellow pages referred by employer patient school nurse

I certify that the information provided above is complete and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Patient Representative Date

ADULT HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL

PAST ILLNESSES

Please check any illnesses you have had.

_____ Asthma
_____ Hay fever
_____ Emphysema
_____ TB
_____ Kidney Trouble
_____ High blood pressure
_____ Rheumatic fever
_____ Diabetes
_____ Stroke
_____ Cancer _____
_____ Anemia (type)
_____ Arthritis
_____ Gout
_____ Abnormal Pap smear
_____ Stomach Ulcer
_____ Mental illness
_____ Seizures
_____ Depression
_____ Back trouble
_____ Bowel trouble
_____ Thyroid disease
_____ Glaucoma
_____ Gallstones
_____ Hepatitis
_____ Liver problems
_____ Bleeding problems
_____ Skin problems
_____ Alcohol problem
_____ Drug addiction
_____ Hearing loss
_____ Polyps of bowel
_____ Sexually transmitted disease
_____ HIV
_____ Other:_____

MEDICATIONS/ALLERGIES

List current medications you take and/or allergies you have:

Medications:

_____
_____
_____
_____
_____
_____

Allergies:

_____

WOMEN ONLY

Age at 1st menstrual period____
# of times pregnant ____
# of living children ____
Date of last Pap smear ____
Age when periods stopped ____
Birth control method:

_____

MEN & WOMEN

Do you consider yourself to be:
___heterosexual (straight)
___homosexual (lesbian/gay)
___bisexual

HOSPITALIZATIONS/SURGERIES INJURIES

Please list any hospitalizations, surgeries, &/or injuries you have had:

_____
_____
_____

FAMILY HISTORY

Please circle any diseases your parents, grandparents, brothers, sisters, aunts, or uncles have had:

Diabetes Asthma Stroke Cancer (type)_____
Alcoholism Seizures Heart Attack High Blood Pressure
Other:_____

NAME: _____ **DATE OF BIRTH:** _____

Office Policy

1. Co-Pays are payable at time of visit. Co-Pays need to be paid each time you visit with the doctor even on follow up visits.

2. Self-Pay patients must pay CASH ONLY! No Checks/Credit Cards will be accepted. Self-Pay patients must pay each time they have an office visit.

3. Patients who take medications on a regular basis need appointments every three months.

4. Any patient that needs medication refills after 3 months need to have an office visit first.

5. Antibiotics will not be prescribed over the phone. In an event of an emergency, Dr. Khan will give a 3-Day supply and patient must follow up within 48-Hours.

6. Referrals and pre certifications will not be done if patient hasn't had an office visit within 3 months.

7. Patient must notify us prior to office visit of any insurance changes otherwise insurance company might not pay and it will be the patient's responsibility.

8. Any address or telephone number changes must be changed with the front desk.

9. Kindly notify us 24 hours prior to cancellation of appointment to avoid $25.00 no-show fee.

10. Blood test will only be done with a prescription.

11. AS OF SEPTEMBER 1ST, 2012, A $10.00 FEE WILL BE CHARGED TO COMPLETE DISABILITY FORMS.

12. Effective January 1st, 2015 completion of all medicals forms will be a charge of $10.00.

SIGNAURE_____ DATE_____

Dewan S. Khan, MD.

Diplomate American Board of Internal Medicine

146 New Brunswick Avenue

Hope lawn, NJ 08861

HIPAA CONSENT
Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

___ Home Telephone_____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Work Telephone _____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Cell Telephone _____
- ___ OK to leave a message with details
- ___ Leave message with call-back number only

___ Written Communication
- ___ OK to mail to my home address
- ___ OK to mail to my work/office address
- ___ OK to fax to this number _____

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

_____ Patient Name (Print)

_____ Birthdate

_____ Signature

_____ Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitue and adequate record

Note: Uses and disclosures for TPO may be permited without prior consent in an emergency.

Record of Disclosures of Protected Health Information

(The section below is to be completed by Office Staff only when disclosing records)

Date	Disclosued to Whom Address or Fax No	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how disclosure was made: F = Fax; P = Phone; E = Email; M = Mail; O = Other

Dewan S Khan MD PC
146 New Brunswick Ave Rear address
Hopelawn, NJ 08861
Phone: 732-697-1919 Fax: 732-697-9247

Patient Responsibly For Follow-Up Care

Acknowledgement and Promise

I._____(print full name), acknowledge and understand that even with the exercise of good medical care, a physician cannot always assure the successful treatment and resolution of my medical problems. Therefore, I understand that it is important that any and all recommendations by my physician are followed promptly and completely in order to increase the like hood of a positive and healthy treatment/outcome.

I acknowledge and understand that if my physician prescribes medicine, it is my sole responsibility to fill the prescription promptly and to take the medicine as directed to completion.

I also understand that if my physician refers me to see another doctor or for a test such as a blood test, and MRI, or CT scan, or other diagnostic study, this recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is my sole responsibility to see the consulting physician or to obtain the recommended test as promptly as possible. I recognize that it is not possible for my physician or her office to follow-up to ensure that I have followed her recommendations. Therefore, I understand that if I fail to promptly see the recommended specialist or obtain the testing for which I was referred, this may compromise my current health or increase future health risks as the result of the failure to follow the advice of my doctors.

Signature of patient or guardian_____ Date_____

Do I Need a Test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Name: _____ Date: _____

Circle "Yes" or "No"

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? Yes No
2. Do you experience foot or toe pain that often disturbs your sleep? Yes No
3. Do you experience any pain at rest in your lower leg (s) or feet? Yes No
4. Are your toes or feet pale, discolored, or bluish? Yes No
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 wks)? Yes No
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? Yes No
7. Have you suffered a severe injury to the leg (s) or feet? Yes No
8. Do you have an infection of the leg (s) or feet that may be gangrenous (black skin tissue)? Yes No
9. Have you ever smoked? Yes No
10. Have you previously had a stroke? Yes No
11. Have you been diagnosed with Diabetes? Yes No
12. Have you been diagnosed with High blood Pressure? Yes No
13. Have you been diagnosed with High Cholesterol? Yes No

Patient Signature: _____

Physician Signature: _____ Note: _____