KAMRAN KHAN MD PC

PATIENT INFORMATION

Patient Name: Last _____ First _____ Mid Initial_____

Address:_____ Home Phone:_____

City:_____ State: _____ Zip: _____ Cell Phone: _____

Date of Birth:_____ Social Security#: _____ Other Phone:_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer:_____ Occupation:_____

Employer Address:_____ Wk. Phone: _____

City:_____ State: _____ Zip: _____

Worked-related Injury: ☐ Yes ☐ No Automobile Accident: ☐ Yes ☐ No Date of Injury/Accident:_____/_____/_____

Emergency Contact:_____ Relationship_____ Telephone:_____

Advanced Directive: ☐ Yes ☐ No Copy on File: ☐ Yes ☐ No Retired ☐ Yes ☐ No

Primary Care Provider:_____ Referred by:_____

PRIMARY INSURANCE INFORMATION

Insured Name:_____ Phone: _____

Address:_____

City:_____ State: _____ Zip: _____

Date of Birth:_____ Social Security#: _____

Employer:_____ Wk. Phone: _____

Employer Address:_____

City:_____ State: _____ Zip: _____

Primary Insurance:_____ Phone: _____

Group#:_____ Policy#: _____

SECONDARY INSURANCE INFORMATION

Insured Name:_____

Address:_____ City: _____ State: _____ Zip: _____

Date of Birth:_____ Social Security#: _____ Phone #: _____

Secondary Insurance:_____ Phone: _____

Group#:_____ Policy#: _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Kamran Khan MD PC. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment to Kamran Khan MD PC. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Kamran Khan MD PC. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency to include but not limited to, commissions, attorney & court filing fees, or interest rates assigned by collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

PATIENT/GUARDIAN SIGNATURE: _____ Date:_____ / _____ / 20____

KAMRAN A. KHAN M.D.
INITIAL VISIT HISTORY & PHYSICAL / REVIEW OF SYSTEMS

Patient's Full Name:_____ Date of Birth:_____/_____/_____ Today's Date:_____/_____/20____

List current/previous doctors and their specialty: _____
_____

Allergies	**Reactions**
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	

PERSONAL MEDICAL HISTORY (please check all that apply)

___ADHD	___Dementia	___High Cholesterol	___Pulmonary Embolism (PE)
___Alcoholism	___Depression	___HIV	___Liver disease
___Allergies, Seasonal	___Diabetes 1 or 2	___Hepatitis	___Rheumatoid Arthritis
___Anemia	___Diverticulitis	___Irritable Bowel	___Seizure Disorder
___Anxiety	___DVT (blood Clot)	___Lupus	___Sleep Apnea
___Arrhythmia	___GERD (Acid Reflux)	___Liver Disease	___Stroke
___Arthritis	___Glaucoma	___Macular Degeneration	___Thyroid Disorder
___Asthma	___Heart Disease	___Neuropathy	___Ulcerative Colitis
___Bipolar	___Heart Attack (MI)	___Osteopenia/Osteoporosis	___Lyme's Disease
___Bladder/Incontinent	___Hiatal Hernia	___Parkinson's Disease	
___Bleeding Problems	___Hypertension	___Peripheral Vascular Disease	
___Cancer:_____ ___	___Kidney Stones	___Peptic Ulcer	
___COPD/Emphysema	___Kidney Disease	___Psoriasis	

Last Menstrual Period (date) _____
Pap (date) _____
Prostate Exam (date) _____

Mammogram (date) _____
Dexa (Bone Density) (date)_____
Colonoscopy (date) _____

Surgeries	Dates

Hospitalizations	Dates

FAMILY HEALTH HISTORY ❑ Adopted

Family Members	Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brothers and Sisters 1) ❑ M ❑ F			
2) ❑ M ❑ F			
3) ❑ M ❑ F			
Sons and Daughters 1) ❑ M ❑ F			
2) ❑ M ❑ F			
3) ❑ M ❑ F			

SOCIAL HISTORY

Occupation: Children: ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How often? How many drinks?

Do you smoke or vape? ❑ Yes ❑ No Packs per day: ❑ ¼ pack ❑ 1½ packs How many years?_____
Are you a former smoker? ❑ Yes ❑ No ❑ ½ pack ❑ 2 packs Year quit?_____
Do you chew tobacco? ❑ Yes ❑ No ❑ 1 pack ❑ Other:_____

Do you use recreational/illegal drugs? ❑ Yes ❑ No

Have you worked with asbestos or other hazardous materials? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No Healthcare proxy? ❑ Yes ❑ No If so, who?
Advanced Directive for Healthcare

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

___Weight gain	___Chest Discomfort	___Breast pain	___Depression
___Weight loss	___Palpitations	___Breast lump	___Blood in stool
___Night Sweats	___Fainting	___Dizziness	___Headaches
___Weakness	___Difficult swallowing	___Vaginal discharge/bleeding	___Persistent cough
___Fatigue	___Indigestion or heartburn	___Penis discharge	___Skin rash
___Insomnia	___Nausea	___Nipple discharge	___Back pain
___Change in hearing	___Vomiting	___Pain with intercourse	___Other:
___Change in vision	___Constipation	___Leg pain/swelling	
___Runny Nose	___Diarrhea	___Memory Loss	
___Nose Bleed	___Change in bowel	___Numbness/Tingling	

habit

___Fever
___Blood in sputum
___Shortness in breath
___Difficulty urinating
___Incontinence
___Frequency of urination
___Feeling too cold
___Tremor
___Anxiety

MEDICATION LIST:

Medication Name	Strength	Dose

Please list all your reason(s) for visiting today in order of priority:

1. _____

2. _____

3. _____

OTHER NOTES TO PROVIDER:

_____
_____

_____
_____

_____
_____

_____
_____

KAMRAN A. KHAN M.D.
Pulmonary Medicine

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my health care, Kamran Khan MD PC originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Kamran Khan MD PC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Kamran Khan MD PC to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

By my signature below I acknowledge that I fully understand and accept the terms of this consent.

X_____ _____
Patient/Legal Guardian Signature Date

5770 S Durango Dr. Ste 105 Las Vegas NV 89113 (702) 737-0740 O (702) 737-1402 F

KAMRAN A. KHAN M.D.
Pulmonary Medicine

Date: _____/_____/ 20 _____

RE: RELEASE OF MEDICAL INFORMATION

Patient Name: _____

DOB: _____ / _____ / _____ Social Security # _____- _____ -_____

I hereby request that Kamran Khan MD PC releases my medical records to:

_____ Dr. _____

Located at _____

Telephone # _____ Fax # _____

_____ Self

_____ Other _____

_____

_____

COST: _____ X .60 per _____ pages. $_____ Total Due

X_____ Date: _____ / _____ / 20 _____
Patient/Legal Guardian Signature

5770 S Durango Dr. Ste 105 Las Vegas NV 89113 (702) 737-0740 O (702) 737-1402 F

KAMRAN A. KHAN M.D.
Pulmonary Medicine

Date: _____ / _____ / 20____

RE: REQUEST OF MEDICAL INFORMATION

Patient Name: _____

DOB: _____ / _____ / _____ Social Security # _____- _____ -_____

I hereby request that you release:

_____

_____

_____

To:

Kamran A. Khan M.D.
5770 S Durango Dr. Ste 105
Las Vegas NV 89113
(702) 737-0740 O
(702) 737-1402 F

X_____ Date: _____ / _____ / 20_____
Patient/Legal Guardian Signature