M. A. Khan, M.D.
Board Certified Dermatologist
4761 Higbee Avenue N.W.
Canton, Ohio 44718-2551
Tel: 330-492-1117
Fax: 330-244-9451
www.makhanmd.com

The Referring Physician Office Staff

Thanks for sending us your referrals.

We request Patients to Pre-Register for Consultation.

Please give these forms to your patients at time of referral
or ask them to download this Registration Package from

www.makhanmd.com

and send it to us to expedite their appointment.
We'll be happy to schedule consultation if we can be of any help.

We appreciate your assistance.

Thanks.
Dr. Khan & Staff

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Fax: 330-244-9451

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Dermatology Consultation

All Referring Physicians

Dear Colleagues,

Thanks for your interest in referring your patients for Dermatology Consultations.
We'll be happy to schedule a consultation visit if we can be of any help your patient.
Patients are advised to pre-register to expedite scheduling of the consultations.
Patients are requested to return to their referring physicians for follow up care.
All registration information can be downloaded from:

www.makhanmd.com

We are happy to provide Dermatology Consultation to all deserving patients referred to us by our regular referring physicians. We are looking forward to a happy professional association. Please feel free to contact us if you have questions regarding this.

Thanks.

Dr. Khan & Staff

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Dermatology Consultation

REFERRING PHYSICIAN: ………………………………… OFFICE CONTACT:……..………………….

DIRECT PHONE NO:……………………………………….. FAX NO:…………………………………….

PATIENT: …………………………………………………… DATE OF BIRTH:………….……………….

CONTACT PHONE NO:……………………………………INSURANCE:………………………….……

CONTACT PERSON:…………………………………………RELATIONSHIP :…………………………..

We'll be happy to schedule a consultation visit if we can be of any help to your patient.
We request patients to pre-register to expedite scheduling of their consultation.
We advise patients to return to their referring physician for follow up care.

REASON FOR CONSULTATION: Itching Rash Acne Spot Growth Wart Mole Other

Please explain:……………………………………………………………………………………………

………

……….

DURATION: ………days ………..weeks ……… months ………years unknown

PAST HISTORY: None Same or list:………………………………………………………………...

FAMILY HISTORY: None Same or list:…………………………………………………………..

DIAGNOSTIC WORK-UP: None or provide Lab Tests Cultures Biopsy Others

TREATMENTS: None or list ……………………………………………………………………...

……….

……….

ANY SPECIFIC QUESTIONS OR COMMENTS: None or list …………………………………….

……….

……………………………………………………………………………..

Referring Physician Signature:……………………………………………………

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All Patients

Please Pre-Register
and
Expedite your Visit

Download
Registration Form
from

www.makhanmd.com

and send it to us

We'll be happy to schedule a visit if we can be of any help.
This will save you precious time.

We appreciate your assistance.

Thanks.
Dr. Khan & Staff

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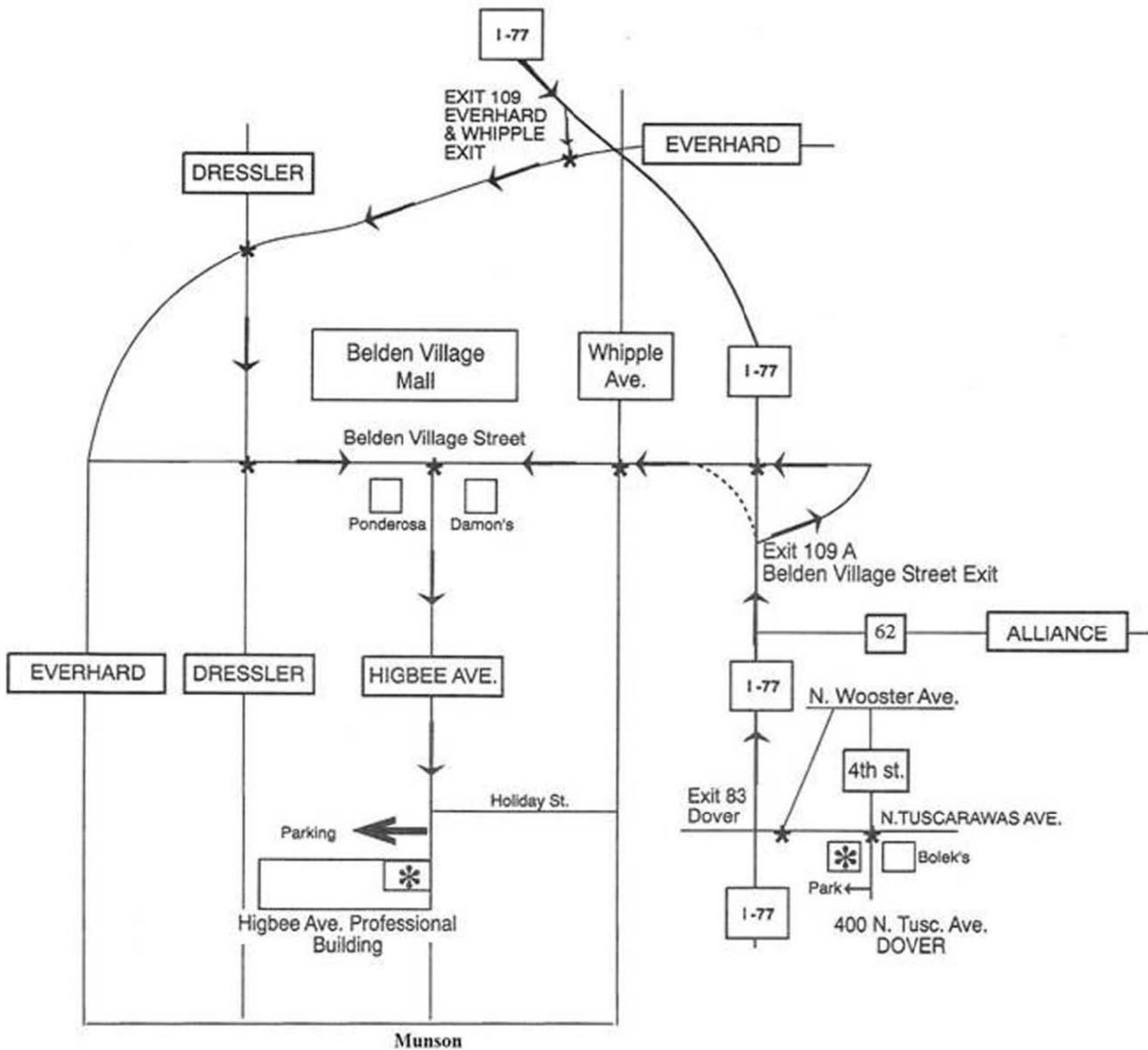

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Canton Office

4761 Higbee Avenue N.W.
Tel: 330-492-1117

From North via Southbound I-77:
1: Take Exit 109 – Everhard-Whipple Road. (Ramp 0.3 miles)
2: Turn right at the traffic light at the end of ramp on Everhard Road.
3: Get into the left lane. (Go 0.3 miles)
4: Turn left at the next traffic light on Dressler Road.
5: Stay in the left lane. (Go 0.2 miles)
6: Turn left at the next traffic light on Belden Village Street.
7: Move to the right lane. The Mall is on your left. (Go 0.3 miles)
8: Turn right at the next traffic light on Higbee Avenue. (Go 0.3 miles)
9: Higbee Avenue Professional Building is the last building on right side.
10: Park in the front parking lot and walk in to the first corner office.

From South via Northbound I-77:
1: Take Exit 109-A – Belden Village-Whipple Road (Ramp 0.3 miles)
2: No turn at traffic light at the end of the ramp. Go straight.
3: You are on Belden Village Street with the Mall on your right. (Go 0.2 miles)
4: Turn left at the next traffic light on Higbee Avenue. (Go 0.3 miles)
5: Higbee Avenue Professional Building is the last building on right side.
6: Park in the front parking lot and walk in to the first corner office.

Dover Office

400 North Tuscarawas Avenue
Tel: 330-492-1117

From North via Southbound I-77:
1: Take Exit 83 – Dover. (Ramp 0.2 miles)
2: Turn left at the traffic light at the end of ramp. (Go 0.4 miles)
3: Go straight passing the railroad crossing. No left turns.
4: Keep right onto North Tuscarawas Avenue. (Go 0.5 miles)
5: Turn right at the traffic light on 4th Street.
The corner building on the right is our office.
6: Enter the parking lot next to the building on your right.

From South via Northbound I-77:
1: Take Exit 83 – Dover. (Ramp 0.2 miles)
2: Turn right at the traffic light at the end of ramp. (Go 0.2 miles)
3: Go straight passing the railroad crossing. No left turns.
4: Keep right onto North Tuscarawas Avenue. (Go 0.5 miles)
5: Turn right at the traffic light on 4th Street.
The corner building on the right is our office.
6: Enter the parking lot next to the building on your right.

M. A. Khan, M.D.
Board Certified Dermatologist
SKIN AND ALLERGY CLINIC
4761 Higbee Avenue N.W.
Canton, Ohio 44718-2551
Tel: 330-492-1117

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used & disclosed, and how you can access it. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service for example an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services the may be of interest to you.

Any other uses and disclosures will be made only with written authorization. Your may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to us.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 15, 2003.

And we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

HIPAA has been amended by the American Recovery and Reinvestment Act of 2009

The patient can bar us from disclosing protected health information (PHI) to their health plans if the patient pays for the item or service in full out of pocket. Patients can direct us to transmit a copy of their information to a designated entity or person, provided that they make their choice "clear, conspicuous, and specific." Your privacy is our major concern. We take all steps to avoid unauthorized release of your PHI.

Please contact us at Skin & Allergy Clinic, 4761 Higbee Ave, NW, Canton, OH 44718-2551, or Call 330-492-1117 for additional information

For more information about HIPAA or to file a complaint, please contact : The U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775

We have an Identity Theft Prevention Program in effect pursuant to the Federal Trade Commission's Red Flags Rule.
We would not disclose any of your information without your "clear, conspicuous, and specific." written authorization.

M. A. Khan, M.D.
Board Certified Dermatologist
4761 Higbee Avenue N.W.
Canton, Ohio 44718-2551
Tel: 330-492-1117
www.makhanmd.com

Patient Instructions & Checklist

Please provide the following ✓ marked documents and forms to expedite scheduling of your visit.

✓ 01: Government ID Card or Driver's License
✓ 02: Participating Insurance cards & Preauthorization (if applicable)
✓ 03: Full Payment or Co-payment - Cash only – (if applicable)
✓ 04: Consultation Request from your physician (if applicable)
✓ 05: Previous health records – please provide all details.(if applicable)
✓ 06: Registration Form…… (completed, dated and signed by an adult)
✓ 07: History Form………… (completed, dated and signed by an adult)
✓ 08: Bring Parents, Legal Guardian or Caregiver (if applicable)
✓ 09: List of all your medications, home remedies and OTC treatments
✓ 10: List of Questions to ask the doctor (if applicable)
✓ 11: List of any disabilities: Mental, Physical, Visual, Hearing, Speech etc.
☞ →: Note our disabilities: Strong allergy to air-borne chemicals and odors.
Avoid all airborne Sprays, Lotions, Powders, deodorants, Perfumes
Bathe with an unscented soap and wear clothes for easy undressing
Partial or Complete undressing is required for proper examination.
Please let the staff know if you need any assistance regarding this.

Dr. Khan is allergic to airborne chemicals, fumes, odors etc.

Your appointment may have to be re-scheduled if he gets an allergic reaction.

We apologize for the inconvenience this may cause you.

Registration Forms provides detailed information about our office policies & practice.
It is standard medical practice to take care of your acute and major problems first.
However all problems will be managed in timely fashion. Your cooperation is appreciated.

We provide "Dermatology Consultation" to patients at the request
of their referring physicians. We do not take over their medical care.
They are requested to return to their referring physician for follow up.

We are an office based practice handling limited skin problems.
We may advise you to seek care from other specialists if we cannot fulfill your needs.
I have received, read, understand & agree to your office policies.

Name →……………………..………………………Sign →……………..…………………………………..Date……….........
Circle → Adult Patient Mother Father Legal-Guardian

Patients without insurance may be entitled to obtain all necessary diagnostic and therapeutic care free of charge through local hospitals, ambulatory medical & surgery clinics, university hospitals & health departments. These facilities are specifically funded by federal, state and local governments to provide various services. We may advise you to seek care at one of these centers if we cannot fulfill your needs.

Do you have any questions, comments or suggestions? No Yes Please list:

M. A. Khan, M.D.
Board Certified Dermatologist
4761 Higbee Avenue N.W.
Canton, Ohio 44718-2551
Tel: 330-492-1117

Surgery Checklist and Authorizations

Please read the following checklist carefully. All the items must be understood and answered completely before the surgery can be scheduled. Please cancel your surgery if you have any unresolved issues.

1: I understand my diagnosis, the recommended treatment, alternative treatments, and the associated risks of the treatments. The physician has answered all my questions to my satisfaction. I understand that no guarantees have been made regarding the outcome. I give this written authorization to perform the procedure.

2: I know that the procedure will be performed in the office under local anesthesia. I am not allergic to local anesthetics, Lidocaine, Epinephrine, Antiseptics, Betadine, Hibiclens, Topical antibiotics, Polysporin, Neosporin, Rubbing Alcohol, Band-Aids, Tapes etc. I never had any untoward reaction to local anesthetics (fainting, palpitations, Angina, irregular heartbeat, difficulty breathing, allergic reaction, shock etc.).

3: I have checked with my doctor regarding any contraindications to surgery. I do not have any uncontrolled heart problem, high blood pressure, diabetes or other medical and/or surgical problems.

4: I do not have any tendency for bleeding and/or poor wound healing.

5: I am not taking any blood thinners or aspirin related products for at least a week before planned surgery and shall not take these medications for a week after surgery. I have checked with my doctor regarding this.

6: I do not need any prophylactic antibiotics prior to surgery because of past history of Rheumatic fever, Mitral valve prolapse, Heart problems, Implants, Prosthetic valves or Artificial joints etc.

7: I shall have someone accompany me after surgery if necessary.

8: I understand the importance of postoperative care and shall return to office for follow up as advised. I shall obtain emergency medical care at the nearest hospital in case any problem arises after office hours, and shall return to the office the next working day for further instructions.

9: I understand the charges for the surgery and pathology examination. I shall obtain all authorizations necessary prior to surgery. I shall be responsible for all deductibles, co-payments and uncovered expenses for the procedures considered cosmetic in nature or medically unnecessary. An appropriate adjustment would be made in the charges if the clinic accepts assignment or has other agreement with your insurance plan.

10: Please write or provide a list of all your present and past Medical and Surgical problems:

11: Please write or provide a list of all your present and past allergies and drug reactions:

12: Please write or provide a list of all your present and past, recent past prescription & over the counter medication:

13: Any other relevant information: Smoker Drinking Pregnancy Hepatitis HIV TB Other please list:

Name →……………………..…………………………Sign →…………..…………………………………..Date………...
Circle → Adult Patient Mother Father Legal-Guardian I know I can cancel this appointment at any time for any reason.

<u>**Do you have any questions, comments or suggestions?**</u> No Yes Please list:

New Patients

Please provide

1: Govt Photo ID or Driver's License

2: Participating Co. Insurance Cards

3: Full Payment or Specialist Co-Pay
whatever is applicable
Cash payment is due at time of visit

4: List of Problems & Medications

5: Checklist, Registration & History Forms
all sections completed & signed by an adult

Don't have all items→ Consider re-scheduling

Update all information at each visit

Please note

Dr. Khan is allergic
to airborne chemicals,
fumes, body odors etc.

He cannot treat patients with body
odors, sprays, lotions, powders,
deodorants, perfumes & colognes.

If you have any airborne chemicals
on you or in your clothing,
consider re-scheduling your visit.

Sorry for the inconvenience

Breathing is Vital
All of us need a little fresh air

M. A. Khan, M.D.
Board Certified Dermatologist
Tel: 330-492-11117
Fax: 330-244-9451
www.makhanmd.com

Patient Name: ____ **Date:** __________________

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Health Plan doesn't pay for the *Service* listed below, you may have to pay.

Health Plan does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Health Plan may not pay for the ***Service*** listed below.

Service	Reason Health Plan May Not Pay	Estimated Cost
❑ Routine Office Exams & Skin Cancer Screenings ❑ Routine removal of skin tags, blemishes, moles, warty growths etc	May be considered Medically Unnecessary by your Medical Insurance Plan	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***Service*** listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your Health Plan cannot require us to do this.

OPTIONS: **Check only one box and Initial. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***Service*** listed above. You may ask to be paid now, but I also want Health Plan billed for an official decision on payment, which is sent to me on a Health Plan Summary Notice. I understand that if Health Plan doesn't pay, I am responsible for payment, but **I can appeal to my Health Plan.** If my Health Plan does pay, you will refund any payments I made to you, less co-pays or deductibles. **Initial:** ______

❑ **OPTION 2.** I want the ***Service*** listed above, but do not bill Ins Plan. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Ins Plan is not billed**. **Initial:** ______

❑ **OPTION 3.** I don't want the ***Service*** listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Ins Plan would pay.** **Initial:** ______

Additional Information: **You may ask your Health Plan for a pre-approval letter.**

This notice gives our opinion, not an official HEALTH PLAN decision. If you have other questions on this notice or your Health Plan billing, please call the number on your Health Plan Summary Notice. Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

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Board Certified Dermatologist
4761 Higbee Avenue N.W.
Canton, Ohio 44718-2551
Tel: 330-492-1117
Fax: 330-244-9451
www.makhanmd.com

Dermatology Consultation

REFERRING PHYSICIAN: ………………………………… OFFICE CONTACT:……..…………………

DIRECT PHONE NO:……………………………………….. FAX NO:…………………………………….

PATIENT: …………………………………………………… DATE OF BIRTH:…………..……………….

CONTACT PHONE NO:………………………………………INSURANCE:………………………….……

CONTACT PERSON:…………………………………………RELATIONSHIP :…………………………..

We'll be happy to schedule a consultation visit if we can be of any help to your patient.
We request patients to pre-register to expedite scheduling of their consultation.
We advise patients to return to their referring physician for follow up care.

REASON FOR CONSULTATION: Itching Rash Acne Spot Growth Wart Mole Other

Please explain:…………………………………………………………………………………………

……

……

DURATION: ………days ………..weeks ……… months ………years unknown

PAST HISTORY: None Same or list:…………………………………………………………………...

FAMILY HISTORY: None Same or list:………………………………………………………………..

DIAGNOSTIC WORK-UP: None or provide Lab Tests Cultures Biopsy Others

TREATMENTS: None or list ………………………………………………………………………...

……

……

ANY SPECIFIC QUESTIONS OR COMMENTS: None or list ……………………………………….

……

……

Referring Physician Signature:………………………………………………………

Dr. Khan received his specialty training at Case Western Reserve University, Cleveland and Albert Einstein College of Medicine, New York.
He is a diplomate of American Boards of Dermatology & Pathology with subspecialty certification in Dermatopathology.
He is allergic to airborne chemicals, fumes, odors etc. He cannot treat patients using sprays, lotions, powders, deodorants, perfumes & colognes.

Our Practice is limited to basic office based management of common localized skin problems. All others cases are referred to Univ. Centers.
If you pre-register, we will schedule your visit only if we feel we can be of some help to you. This may save you time & money.
All Patients with multiple, difficult, complicated, serious, medico-legal, or job-related problems are referred to Univ. Centers.
Good Patient-Physician relationship is based on mutual courtesy, respect, dignity and an open, honest, caring communication.
You are entitled to receive risk-benefit ratio & cost of various diagnostic & treatment options, and our recommendations.
You have the right to make decisions regarding your health. You may accept or refuse our recommended medical treatment.
Please feel free to discuss all your concerns. All information is confidential and can be released only under applicable laws.
We advise second opinions & consultations with Univ. Centers if we feel the problem is beyond the scope of our expertise.

Initial Visit: It is standard medical practice to evaluate and treat major problems first on a high priority basis.
If you have multiple problems, all of them will be managed in timely fashion.
Proper care may require involvement of your family physician and referral to other physicians.

Follow Up: Prescription drugs require regular follow up. Pathology & Laboratory test results are discussed during your follow up visits.
Follow up evaluations are an important component of medical care. Your active participation in your care is very important.

Surgery: We do not perform Laser, Cryo or Cosmetic surgery. Surgery always leaves some scarring & discoloration even lumpy scars.
Dr. Khan will discuss & schedule the surgery. There is no urgency in office procedures. You may plan at your convenience.
Any new mole–growth or one showing changes in appearance or sensation needs to be removed for definitive diagnosis.
The only sure way to differentiate between Benign & Cancerous mole/growth with almost 100% accuracy is by Pathology Exam.
We recommend Plastic surgery consultation and second opinion regarding alternative methods for optimum cosmetic results.
Insurance companies & Medicare do not pay for Skin Cancer Screening or Removal of Benign Growths- Blemishes, Moles, Skin Tags, Warty Growths etc.

Precautions: Drug interactions occur with all prescription and non-prescription products even foods. Topical medications are drugs.
Please coordinate your care with your doctor if you are on multiple drugs for other medical problems. Be fully informed.
Avoid exposure to things that make your condition worse. Some medication will make you drowsy &/or cause a severe sunburn.

Ladies: Pregnant and Breast Feeding women should avoid almost all oral and topical medication unless absolutely necessary.
Oral antibiotics may reduce the efficacy of Birth Control Pills. Ask your doctor regarding the need for additional contraception.

Side Effects: All oral, topical medications and surgical procedures can cause bad reactions. Please go to the nearest hospital emergency room.
All acute or severe reactions require immediate trip to the nearest hospital emergency room for prompt evaluation and treatment.
If you notice anything unusual, please stop the medications; go to hospital emergency room and schedule an earlier office visit.

You are strongly advised to ask questions & obtain all the answers to your satisfaction before you leave the office.
Studies have shown that the patients may recall only a portion of what was discussed during their visits.
Please call us if you have any questions about your visit.

Patient Name First ………………… Middle ………………… Last ………………… Date of Birth ………………… Soc Sec No …………………

Home Address ………………… City ………………… Zip Code ………………… Home Tel. …………………

Work Address ………………… City ………………… Zip Code ………………… Work Tel… …………………

Authorized Contact Person ………………… Relationship ………………… Emergency & Cell Phone # …………………

Insured Name First ………………… Middle ………………… Last ………………… Soc Sec No ………………… Relationship Self Parent Spouse

Primary Ins Medicare or List ………………… Secondary Ins Medicaid or List …………………

Provide Driver License Govt. ID Card Insurance Cards **Alternate Emergency #** ………………… **Please circle & provide all details ➔©**

Patient, Parent (if minor) or Legal Guardian, please sign the following authorizations. A copy of this would be as valid as the original.
I have received, read, understand & agree to abide by the above policy. I authorize clinical evaluation and treatment as indicated.

I will follow the above advice to reduce side effects & complications.
I know audiovisual recordings may be made of all my calls and visits.
I authorize payments of medical benefits to Dr. Khan &/or the Clinic.
I authorize release of all the information to my physician &/or insurer.
I authorize release of all information to my authorized contact person.

I understand missed follow up visits may have serious consequences.
I shall obtain additional services only after knowing the exact charges.
I am responsible for uncovered services, deductibles & co-payments.
I understand there is a separate charge for each and every office visit.
I know cash pre-payment is required if my insurance is not accepted.

I have received written information on the Health Insurance Portability & Accountability Act Policy covering the security and privacy of my health information

Name ➔ ………………… **Sign ➔** ………………… **Date** …………………
Circle ➔ Adult Patient Mother Father Legal-Guardian

Do you have any questions, comments or suggestions? No Yes Please list:

M. A. Khan, M.D.
Board Certified Dermatologist
Evaluation & Management

Date .... **Patient** .... **Date of Birth** .... **Referred by** *none* or **Dr.** ....

Sex m f **Marital status** s m d w **Age** .... **Skin Type** .... **Type of work** child student home retired *none* or ....

Past, Present Problems & Review of Systems *None* Psych/Neuro Depression Memory Alzheimer Seizures Dizzy Spells Headaches Stroke Diabetes Thyroid Hormone ENT Hearing Mouth Teeth High Blood Pressure Cholesterol Heart Disease Heart Attack Irregular Heart Beat Palpitations Murmur MVP Bypass Pacemaker Shortness of Breath Asthma Anemia Lymph Nodes Cancer Arthritis Lupus Muscle Bone Prostate Kidney Urinary Genital Digestive Reflux Gerd Peptic Ulcers Colitis Cataract Glaucoma Allergies Hay fever Hepatitis B C TB HIV STDs Infectious Diseases General Constitution Recent Weight Loss Weight Gain Tired Fever Frail Obese Disabled Radiation Surgeries & others. Please write down all your symptoms & medical problems or provide a list.

Medications *None* Psych/Neuro Heart Circulation Blood Pressure Seizure Diabetes Pain Infections Arthritis Allergy HRT Steroids Weight Loss Drugs Prescriptions Non-Prescriptions Over-the-Counter Home Remedies Street Drugs Narcotics Alcohol Tobacco &/or Others Please write down generic &/or brand names of all products or provide a list.

Family Hx *None* Acne Eczema Dermatitis Psoriasis Allergies Drug Reactions Fungus Abnormal Moles Melanoma Skin Cancer Lupus Hair Loss Thyroid Disease Arthritis Diabetes Heart Disease High BP Stroke Seizures Cancer Glaucoma Cataract Keloids Adopted Unknown Similar Same &/or Other Disorders. Please list names of all family conditions:

Surgery Patients High BP Angina Heart-Circulation Irregular Heart Beat Stroke Palpitations Diabetes Infection Fainting Implants Prosthetics Dizzy Spells Blood Thinners Aspirin Arthritis-meds Cortisone Bleeding Poor Healing Lumpy Scars Keloids
Any Reaction to: Lidocaine Anesthetics Epinephrine Antiseptics Bandaid Tapes Antibiotics *None* &/or others Please list below.

Female Patients **Pregnant** No Yes months **Breast Feeding** No Yes months **Planning Pregnancy** when? **Frequent Yeast Infection** Yes No
Birth Control *None* No-Sex Menopause Uterus-Removed Tubes-Tied Patch IUD Husband-Fixed Condom or **Pill-Brand name** for Years

Drug Allergies *None* Penicillin Tetracycline Sulfa Erythromycin Cephalosporin Doxycycline Minocycline Epinephrine Cortisone Antihistamines Anesthetics Codeine Topical medications &/or others Please list generic &/or brand names of all products:

☐ **Chief Complaint** **Circle & describe** → Acne Spot Mole Wart Growth Rash Itching &/or other Please describe below.

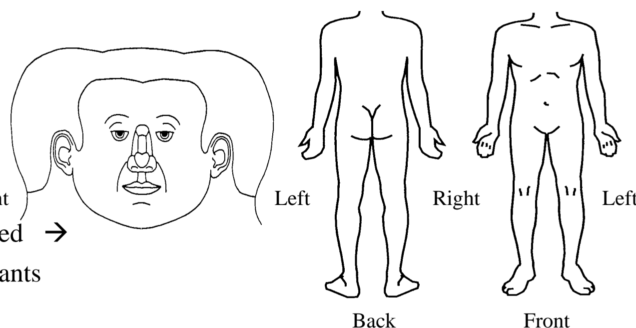
For how many? ......days ......weeks ......months ......years *unknown*

Quality No-Symptoms Itching Irritating Painful Non-Healing Changing Suspicious Unsightly Bothersome Upsetting &/or list

Discomfort *None* Mild Moderate Severe **Onset** Sudden Gradual

Timing Acute Chronic Persistent Recurrent

Severity Mild Moderate Severe Extensive **Extent** Generalized Localized →



Please mark the location

Aggravated by *None Unknown* Nerves Stress Menses Contact Allergy Plants Chemicals Work Sports Hobbies Drugs &/or list:

Other Signs & Symptoms *None* Psychological Social &/or list:

Dermatologists &/or Physicians seen *None* or list:

Present Skin Diagnoses & Treatments *None* or list:

Past Skin Diagnoses & Treatments *None* Same or list:

Any other relevant information *None* or list:

Proper Skin Exam usually requires partial or complete undressing. Please let the staff know if you need assistance.

I have circled & provided all details. I know incomplete or incorrect information may be hazardous to my health.
I'll schedule an appointment if I notice a change in a mole, growth or blemish and/or a new lesion of any type.
I know I can call the office if I have any questions about my visit, medications and treatment plan at any time.
I'll seek 'hospital emergency care' in case of any reaction–complication. I'll stop all your meds & notify you.

Name →.................................... **Sign →**.................................... **Date**............
Circle → Adult Patient Mother Father Legal-Guardian

Do you have any questions, comments or suggestions? No Yes Please list:

New Patients
Please provide

1: Govt Photo ID – Driver's License

2: Participating Co. Insurance Cards

3: Full Payment or Specialist Co-Pay
whatever is applicable
Cash payment is due at time of visit

4: List of Problems & Medications

5: Checklist, Registration & History
all sections in each form
completed and signed by an adult

Don't have all items→ May Re-schedule

Update all information at each visit

All Patients

Please note

Dr. Khan is allergic
to air-borne chemicals,
fumes, body odors etc.

He cannot treat patients with body
odors, sprays, lotions, powders,
deodorants, perfumes & colognes.

If you have any airborne chemicals
on you or in your clothing,
consider re-scheduling your visit.

Sorry for the inconvenience

Breathing is Vital
All of us need a little fresh air