

### 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.

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

## **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**

# **New Patients**

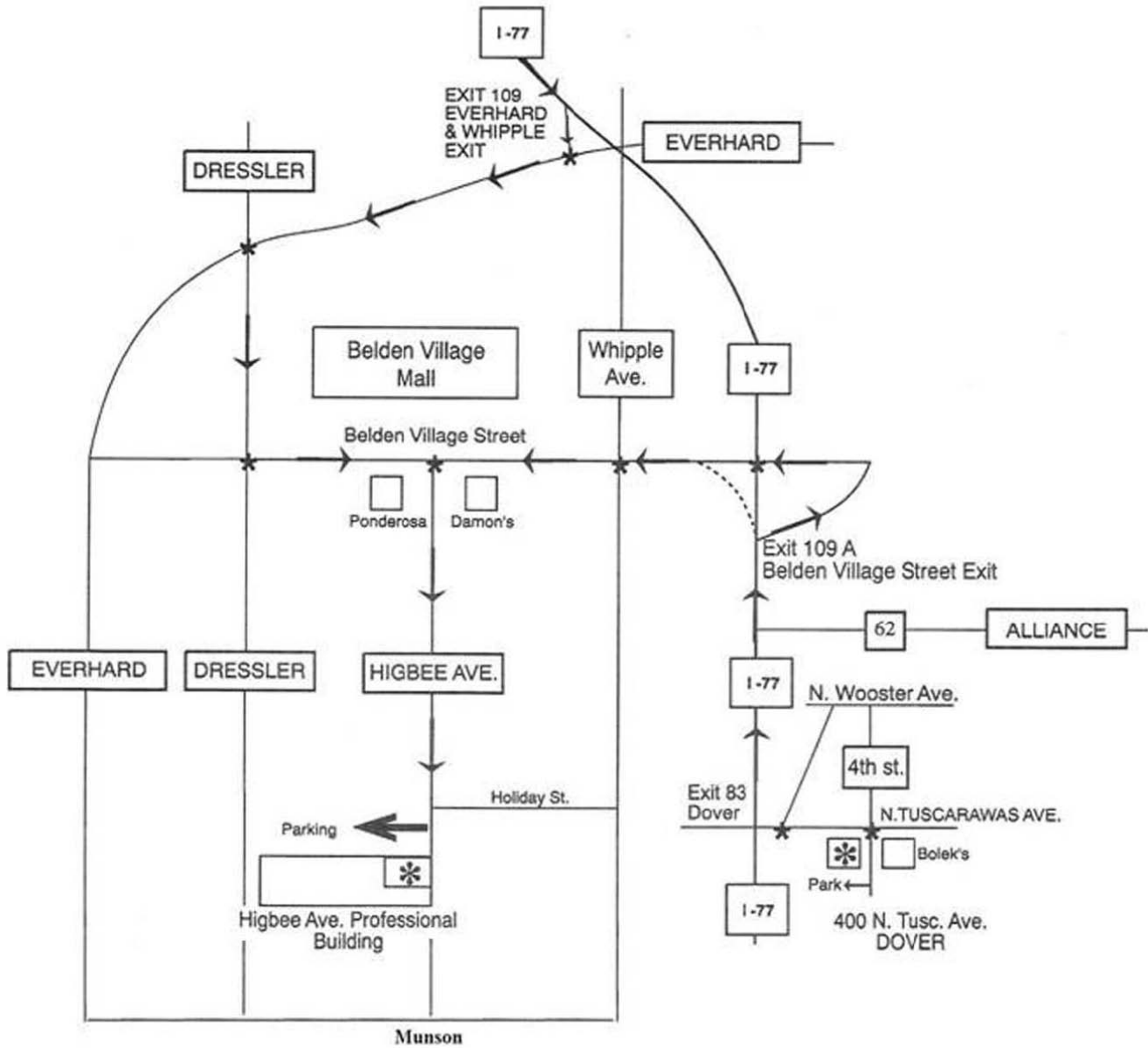
## **Please provide**

- 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**

**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



# **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

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