Misbah Khan, MD FAAD FACMS
345 East 37th Street, Suite # 309
New York, NY 10016
917-853-DERM (3376)
info@mkhandermatology.com

Fellow American Academy of Dermatology
Graduate American College of Mohs Surgery
Fellow American Society of Dermatologic Surgery
Fellow American Society of Laser Medicine and Surgery
Assistant Clinical Professor Dermatology Weill Cornell Medical College

Patient Registration Form

Patient Name____

Date of Birth____

Address: ____

____

Social Security # ____

Gender ___________________ Minor ____________________

Home Phone (_____) ____________ Cell ______________________

Work (____) __________________ Ext ________________________

Best time and Place to reach you

____

Email ____

Employer ____

Occupation ____

Primary Care Physician (Name and Address)

____

Who referred you to us? ____

May we thank them? ____

Marital Status: Married_____ Widowed ______ Single _____ Divorced ____

In case of emergency, Contact:

Name & Relationship to patient: ____________________________________

Home phone: ___________________ Cell: __________________________

Billing Information:

Who is responsible for this account? ________________________________

DOB: ___________________

Relationship to the Patient: _____________________________________

Social Security # ____

Insurance Assignment and Release

My visits to M Khan Dermatology will not go through my medical insurance carrier due to the fact that: (check all that applies)

1. I do not have medical insurance coverage, so I accept responsibility to pay in full
2. I am visiting this office strictly for cosmetic reasons, not medical, so I accept responsibility to pay in full.
3. My treating physician, Dr Khan, does not accept medical insurance, so I accept responsibility to pay in full

____ _____________

Name and Signature of the patient, beneficiary, guardian or representative Date

PATIENT MEDICAL HISTORY

ALL QUESTIONS MUST BE ANSWERED. IF A QUESTION DOES NOT APPLY TO YOU, WRITE “NONE” OR “N/A” FOR NOT APPLICABLE

Patient Name: ____

DOB: ____

Dermatologic History

1. Reason for visit: ____
2. How long this has been going on?

____

3. What areas are being affected?

____

4. How has this been treated so far?

____

5. Other Skin conditions

____

6. Topical (Skin) Medications prescriptions and over the counter

____

Khan Dermatology

Detailed Medical History

Please answer all questions. If answered "YES" please provide the list of medications you are using or have used to treat that particular Medical condition.

Medical Conditions	Yes	No
Anemia		
Arthritis		
Artificial joints/ joint disorder		
Asthma or other related lung problems		
Cancer		
Cardiac Pacemaker		
Cold sores, fever blisters		
Depression or other related disorders		
Diabetes		
Eye disorders / Glaucoma		
Hay fever / Allergies		
Heart Disease / murmur		
Hepatitis		
High blood pressure		
History of skin Cancer / previous Mohs surgeries		
HIV infection / AIDS		
Keloids / Red Scars		
Kidney / Bladder problem		
Mitral Valve Prolapse or other related heart conditions		
Neurological Disorders		
Radiation Therapy		
Recent weight loss or weight gain		
Rheumatic Fever		
Seizures		
Stomach / Bowel Problems		
Stroke		
Thyroid Disease		
Ultraviolet Light Therapy		

Do you take any medications on a regular basis? If yes, please provide a detailed list below:

____

____

Family history of skin cancer / skin diseases if any

____

Please list any surgeries you have had in the past

____

Do you need antibiotics before any surgical procedures? If yes, please provide the names

____

List any other medical conditions for which you are currently being treated

____

Are you allergic to any medications, related substances, foods, shellfish etc. Please list all

____

Do you have any history of prolonged bleeding during surgeries or blood clots

____

Women ONLY: Are you…..
Pregnant or think maybe? __________________
Nursing? __________________
Taking oral contraceptives?_________________
Taking hormone replacements? _____________

_________________________________	Misbah Khan, MD FAAD___________
Patient Name	Physician Name
_________________________________	_________________________________
Patient Signatures	Physician Signature
_________________________________	_________________________________
Date	Date

____

Signature of the Guardian if under 18 yrs of age

Khan Dermatology

COSMETIC PROCEDURE QUESTIONAIRRE

Patient Name: ____

Aesthetic issues and areas of concern/interest that you would like to talk to Dr Khan about:

1. Liposuction Revision/Defects
2. Knee Contouring
3. Body contouring
4. Neck liposuction and neck lift
5. Lip Augmentation
6. Lip lift Surgery
7. Ear Lobe repair
8. Eyelid surgery
9. Fat grafting
10. Fraxel and or Fractional CO2 laser treatments
11. Frown lines/forehead lines
12. lines around the mouth and nose
13. tired looking skin/ skin sagging
14. large pores, clogged pores
15. Brown and or Red spots
16. Liposuction
17. Sun damage
18. Scars (acne and other related)
19. Leg Veins
20. Rosacea, facial redness
21. excessive sweating
22. Hair loss with PRP and Tissue matrix/stem cells
23. Cellulite
24. Tattoo Surgery / removal

What cosmetic procedures you have had in the past? Please list all

____

Were you satisfied with the results? If not please explain why

____

____

CONSENT TO PHOTOGRAPH

1. I consent to be photographed during the course of my treatment with MKhan Dermatology. I understand the purpose of such photographs is to track the progress of my treatment (s). I understand that my photographs are part of my medical records and are therefore a property of MKhan Dermatology.

____

Patient Name, Signature and Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

Below please list the name (s) relationship of any person other than yourself that you authorize MKhan Dermatology P.C., to release your medical information to.

1. I authorize the following third parties (i.e., spouse, parent, partner etc) to view or receive verbal information regarding my record (s):

____

Print Name and Relationship

____

Patient Name and Signature

2. I do NOT authorize the release of my medical information to any third parties.

____

Patient Name and Signature

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I hereby give my consent for M Khan Dermatology, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) (M Khan Dermatology, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures).
I have the right to review the Notice of Privacy Practices prior to signing this consent, M Khan Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to M Khan Dermatology, P.C.'s main address 345 East 37th street Suite #309, New York, NY 10016.

With this consent, M Khan Dermatology, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
With this consent, M Khan Dermatology, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and material related to my clinical care as long as it is marked Personal and Confidential.

With this consent, M Khan Dermatology, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and material pertaining to my clinical care. I have the right to request that M Khan Dermatology, P.C. restrict how it uses or discloses my PHI to carry out my TPO. M Khan Dermatology P.C. is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to M Khan Dermatology, P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, M Khan Dermatology, P.C. may decline to provide treatment to me.

____

Patient name, Signature and Date

____

Print Name and Signature of Legal Guardian or Parent Date

ACKNOWLEDGEMENT OF INSURANCE PLAN NON-PARTICIPATION

____

Patient Name and Date

I am fully aware that Misbah Khan, M.D. is non-participating with any/all medical insurance carriers. I acknowledge and agree that I am fully responsible for any/all costs incurred for my treatment in this office, whether that treatment is of a medical or cosmetic nature. I understand that I am responsible to pay the full cost that MKhan Dermatology has determined to be appropriate for the treatment I receive.

I also understand that I am personally responsible for insurance submission of claims should I choose to attempt to obtain reimbursement from my health insurance carrier.

____

Patient Signature and Date

NO SHOW / CANCELATION POLICY FOR CONSULTATION (MEDICAL AS WELL AS COSMETIC) VISIT

If it is necessary for you to cancel your scheduled appointment we ask that you call by 10am one (1) business day in advance. Appointments are in high demand, and your early cancellation will give another patient the opportunity to access timely care.

NO SHOW / CANCELATION POLICY FOR COSMETIC OR MEDICAL (SURGICAL) PROCEDURES
Cosmetic or Medical procedures are subject to at least a 2-week cancellation notice. If you are unable to keep your appointment due to medical reasons we require you submit a letter from your primary care doctor's office. Although Facility fee or Operating room fees are non-refindable (see below), additional charges can be credited back to the patient upon receiving the letter.

How to Cancel Your Appointment
To cancel a scheduled appointment, please call
Manhattan Office – 917-853-DERM (3376) or EMAIL us at info@mkhandermatology.com

If you do not reach a receptionist, please leave a detailed message with our answering service.

Late Cancellations for Consultation
Late cancellations i.e., less than a 24 hour (one business day) notice for a Medical/Cosmetic consultation visit; OR less than 2 week notice for a medical/cosmetic (surgical) procedure, will be considered a "no show".

No Show Policy
A "no-show" is someone who misses an appointment without canceling it by 10am one (1) working day in advance.

No-Show/Late Cancellation Fees
Any Medical appointment that is a "No Show" is subject to $350/visit
Any Cosmetic procedure appointment that is a "No Show" will result in a fee of $350.00
Any Cosmetic Surgical Appointment for which an Operating Room had to be reserved for will result in a charge consisting of Facility Procedure Room Fee or Operating Room fees (non-refundable) + 50% of the total of the cost of the procedure as determined by Dr Khan (can be refunded in case of an emergency cancellation/no show).

If you are unable to keep your scheduled appointment, we want to remind you of the importance of follow up treatments as indicated by your physician.

We reserve the right not to refill prescriptions or see the patient until any cancellation/no-show fees are paid in full. Please note that if you are running late for your scheduled appointment, you should call to alert the office. While we will do our best to accommodate late patients, we may have to reschedule your appointment based on availability.

This agreement is entered on: (Date) ___________________________________

____
Patient Name and Signature and Date

____
Print Name of Legal Guardian or parent if a minor, signature and Date