KASHAN KHAN, M.D.

Dr. Kashan Khan,
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NEW PATIENT PACKET

PATIENT INFORMATION – PLEASE PRINT			
NAME (Last, First, Middle)	BIRTHDATE (MM/DD/YYYY) / /	SSN	GENDER
LOCAL ADDRESS	CITY, STATE, ZIP		
RACE:	LANGUAGE:	EHNICITY ☐ HISPANIC ☐ NON-HISPANIC ☐ OTHER	PHARMACY NAME: PHONE: ( ) -
EMPLOYER'S NAME / EMPLOYER'S ADDRESS / OCCUPATION		REFERRED BY:	

*I allow Orlando & St. Cloud Family Medicine to **CALL OR TEXT** me on the specified number(s).*

HOME PHONE ( ) - CELL PHONE ( ) - WORK PHONE ( ) -

Email Address: _____ @ _____.com

☐ YES *I allow Doctor's office to **EMAIL** me .*
☐ NO *I do not allow Doctor's office to **EMAIL** me.*

Doctor's office encourages the use of the patient portal as we go green by minimizing the printing of paper. The patient portal is a secured system operated by a password-protected login and allows patients on-line access to their medical records.

ASSIGNMENT OF BENEFITS

It is therefore **my sole responsibility as the patient to know my insurance company coverage**, including which laboratory, medical provider or facilities my insurance company is contracted with. I will not hold Dr Kashan Khan and its management responsible for any bills incurred regarding any expenses or errors pertaining to me going to a non-covered laboratory, medical provider or facilities.

A photocopy of the Assignment shall be considered as effective and valid as the original. **I** also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Ins. Card holder (if not patient): _____ DOB: _____ SSN_____ Relationship_____

By signing, I hereby acknowledge that all the information provided above is accurate and true. I have also read and understood the **Notice of Privacy Practice**, **Patient Policies** and **Financial Policies**, which states that I am fully responsible for any services, balances, and/or no-show fees incurred.

_____ _____/_____/_____

PATIENT / RESPONSIBLE PARTY (SIGNATURE) **DATE**