Yasmin B-Khan, M.D., FACOG
Catherine Nipper, W.H.C.N.P.,B-C
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Obstetrics & Gynecology
1080 W. Campbell Rd. Suite 200
Richardson, TX 75080
(972) 498-4510

PATIENT INFORMATION FORM

DATE: _____

PATIENT NAME_____AGE_____ SEX_____DOB_____
ADDRESS_____ APT #_____SS#_____
CITY_____ STATE_____ZIP_____
EMAIL ADDRESS_____ MARITAL STATUS_____

PRIMARY PHONE_____CELL PHONE_____OTHER PHONE_____
WHICH PHONE # WOULD YOU PREFER TO BE CONTACTED AT? [] PRIMARY [] CELL [] OTHER
WHAT IS THE BEST TIME TO REACH YOU? [] MORNING [] AFTERNOON [] LATE AFTERNOON

EMPLOYER_____OCCUPATION_____
ADDRESS_____CITY_____STATE_____
ZIP_____ PHONE/EXT_____

DO YOU HAVE HEALTH INSURANCE? [] YES [] NO [] PRIVATE PAY
WHICH HEALTH INS. COMPANY? [] BCBS [] AETNA [] CIGNA [] UHC [] OTHER_____

INSURED
NAME_____DOB_____ SS# _____
HOME ADDRESS_____CITY_____STATE_____ ZIP_____
RELATIONSHIP TO YOU _____ EMPLOYER _____
WORK PHONE _____ CELL _____

SPOUSE
NAME_____ DOB_____SS#_____
EMPLOYER_____WK#_____CELL#_____

PHARMACY NAME_____PHARMACY PHONE_____
PHARMACY ADDRESS_____

REFERRING PHYSICIAN_____
REFERRING PHYSICIAN ADDRESS & TELEPHONE_____
_____

EMERGENCY CONTACT NAME & NUMBER _____
THEIR RELATION TO YOU_____

I HERBYAUTHORIZE ANY AND ALL INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED BY ABOVE INSURANCE COMPANY. I AUTHORIZE TREATMENT BY DR. YASMIN KHAN AND STAFF.

PATIENT SIGNATURE_____

Name:_____Date:_____Age:_____Marital Status:_____Occupation_____

The reason for your visit today:_____

# of Pregnancies_____# of Full term_____# of Living_____# of Premature_____# of Miscarriages_____

# of Abortions_____# of Ectopics_____ # of Normal deliveries_____ # of Cesarean-sections_____

Last Menstrual Period:_____How many days between periods?_____

How long does the flow last?_____ What age did your period start?_____

Have you had: [] Irregular Cycles [] Heavy Cycles Prolonged Cycles [] Short Cycles

What methods of contraception do you and your partner use?_____

Have you had: [] Tubal Ligation [] Essure

Have you ever taken contraceptive pills, if so when and for how long? _____

Have you ever had: [] Migraines [] Blood clots in your legs, etc. from birth control pills

Have you ever had an IUD? [] Mirena [] Paragard if so, when and for how long? _____

Have you ever had a sexually transmitted disease (i.e, Gonorrhea, Chlamydia, venereal warts, PID,

Syphilis, Herpes, and HIV)?_____

Do you have any urinary problems/loss of urine on coughing?_____

Have you ever had ovarian cysts?_____When_____ Fibroids?_____When_____

When was your last pap smear?_____ Mammogram?_____Colonoscopy?_____ Bone Density_____

Any problems with intercourse?_____

Have you ever had an abnormal pap smear? _____

Have you ever had an abnormal mammogram?_____ [] Breast Cyst [] Lumps [] Biopsy

Have you had a hysterectomy?_____ []Abdominal [] Vaginal [] Laparoscopic [] Ovaries removed

Have you had: [] Leep [] D&C [] Laparoscopy

Medical Problems:	[] Asthma	[] Thyroid Prob	[] Endometriosis
	[] High Blood Pressure	[] Depression	[] Diabetes
	[] Migraines	[] Heart Disease	[] Cancer

Any serious illness? _____

List any surgeries and injuries, with dates and hospitals _____

_____

_____

List current medications and health conditions being treated with each medication (including non-prescription,

herbs)_____

Have you had?: [] TDAP (tetanus/whooping cough vaccine) [] Hepatitis vaccine [] Gardasil (HPV vaccine) When_____

Family History:	Breast Cancer_____	High blood pressure_____
	Colon Cancer _____	Ovarian Cancer_____
	Uterine Cancer _____	Heart Disease _____
	Diabetes_____	Stroke_____
	Thyroid Problems _____	

Other conditions and illnesses in family_____

_____

Do you have any allergies to medications?_____Are you allergic to Iodine/Peanuts/Latex/IV dyes/Eggs

Do you smoke?_____Drink alcohol?_____Drink caffeine?_____

Who is your family doctor or doctor you are currently seeing?_____

Are there any personal matter you would like to discuss after today's exam?_____

In the event of an emergency, will you accept blood products/transfusion? □ Yes_____(initial) □ No_____(initial)

Yasmin B. Khan, M.D., FACOG
General Consent for treatment as approved by the Texas Medical Association.

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instruction of the Physician of Yasmin B. Khan, M.D., P.A. and associates. I am responsible for determining my insurance coverage for services through this practice.

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examinations by Yasmin B. Khan, M.D., P.A. and associates.

_____ _____
Printed Name Signature and Date

Private Health Information

Check all that apply:

- ☐ You may contact me on my: ☐ Cell ☐ Home ☐ Work
- ☐ You may leave a detailed message on my voice mail ☐ Cell ☐ Home ☐ Work
- ☐ You may contact me by fax# _____
- ☐ **Do not** leave messages

Please list any persons to whom we may release your private health information.
If you do not list their name, including husband, we cannot speak to them.

Husband _____ PH# _____
Mother _____ PH# _____
Relative _____ PH# _____
Friend _____ PH# _____
Other _____ PH# _____

Please list any special instructions regarding your private health information here:

_____

I understand :

- I will receive my results through the patient portal **only** within 7-10 business days.
- Critical results will be relayed through a phone call from the provider or medical assistant.
- I will use the patient portal for all communications.
- In an emergency only, I may use the answering service at (214) 373-2442.
- Non-emergency calls to the answering service may not be returned.
- Prescription refills should be directed to the pharmacy.

_____ _____
Patient signature Date

YASMIN B. KHAN, MD, FACOG / *Obstetrics & Gynecology*

403 W. Campbell Road *Ph:* *(972)498-4510*
Suite 305, Medical Plaza I *Fax:* *(972)498-4511*
Richardson, Texas 75080

FINANCIAL POLICY

We are dedicated to providing the best possible OB/GYN care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss them with us.

FEES
For those insurance plans in which we participate, your predetermined portion of charges set by your insurance plan is **due at the time of services**. This includes all co-payments and deductible amounts. For your convenience, we will accept cash, checks, VISA, MasterCard, Discover, and American Express. All patient percentages will be determined by your insurance company once any reduction in fee is necessary, and you will be billed for the remainder.

The patient is responsible for all accounts regardless of insurance coverage within 60 days after the date of treatment. We make every effort to follow the guidelines required by your insurance company, however, every contract is unique. Every effort is made to file claims on your behalf with your insurance company. Unfortunately, if we are unable to collect payment from your insurance company within 60 days, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

This office makes every attempt to verify benefits. All patients are responsible for any balances on their account regardless of insurance company verification or pre-certification. Please remember that verification of benefits or pre-certification does not guarantee payment by any insurance company. Any overdue balances are subject to being sent to an outside collection agency.

All phone consultations are subject to a charge. All additional paperwork/letters requested by a patient are subject to additional fees. Same day requests have additional charges.

A $25.00 service charge will be assessed for returned checks, and must be paid in cash.

MINOR PATIENTS
For all services rendered to minor patients (under 18 years of age), we will look to the adult accompanying the patient and to the custodial parent or guardian for payment. We will not disclose any confidential information to the parent or guardian without written or verbal consent of the minor.

CANCELLATION POLICY/MISSED APPOINTMENTS
It is the office policy to bill the patient (not the insurance company) a $25.00 fee for cancellations not made 24 hours in advance prior to their appointment. Please call to cancel or reschedule your appointment 24 hours so we can accommodate others as a courtesy. We try to make reminder calls to confirm appointments but patients are expected to be responsible for their appointments as there are times we cannot make the reminder calls.

As a courtesy for those who come to their appointment early or on time, patients who arrive late will most likely be asked to reschedule.

MEDICAL RECORDS
A copy of medical records will be furnished to a physician upon written request from the physician or patient. An Authorization for Release of Medical Records form must be completed and signed by the patient. A fee will be accessed to the patient for this request and is payable in full prior to the release of records.

TERMINATION OF TREATMENT
The treating doctor reserves the right to terminate treatment with patients who are non-compliant with office policies.

I have read and understand the financial policies of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Responsible Party Relationship

Yasmin B. Khan, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with the Notice of Privacy Practices. Please let the receptionist know if you would like a copy.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____

_____

_____

_____

_____

_____

_____

_____

Pristine Med Spa
Yasmin B. Khan, M.D.

Spa Interest Questionnaire

Name: _____ Date: _____

Phone#: _____ **Birthday:** _____/_____/_____

Email: _____ **May we send you emails about our promotions?** Y N

What are your areas of concern? (Check all that apply):

____ Frown lines around nose & mouth
____Rough skin texture
____Body Hair
____Facial Hair
____Acne
____ Fine lines and wrinkles
____ Sagging skin
____ Hyperpigmentation/ Freckles
____Thinning hair/hair loss
____Dry Skin

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about my appearance.

Not Concerned *Somewhat Concerned* *Very Concerned*
1 2 3 4 5

If you could improve anything about your appearance what would it be? _____

Are you interested in learning more about the following?

___ Botox/ Dysport
___ Cosmetic filler
___Sun Protection
___Chemical Peels
___Anti-Aging/ skin rejuvenation
___ Acne topical treatments and creams
___laser hair removal
___ Acne Scar Reduction

Going back three generations what is your heritage? _____

Fitzpatrick Skin test (Please circle one):

Type I: Always burns, never tans

Type II: Somewhat tans, mostly burns.

Type III: Tans after initial burn

Type IV: Sometimes burns, mostly tans

Type V: Rarely burns, almost always tans

Type VI: Never burns, always tans darkly

Please circle any previous cosmetic treatments:

Chemical Peel
Botox/Dysport
Retinol Products
Facials
Cosmetic surgery, please specify: _____
Cosmetic Fillers
Microdermabrasion
Laser Hair Reduction

Are you currently being treated at another medical spa, or dermatology office? (please circle) Y or N

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger (1st degree relative)	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger (1st degree relative)	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
If you have a family history of any **other cancers**, list them here:				
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with Myriad myRisk® ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with Myriad myRisk®
☐ COLARIS®PLUS with Myriad myRisk® ☐ COLARIS AP®PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update
☐ Other _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

MYRIAD **myRisk**® Hereditary Cancer

Cuestionario sobre Antecedentes Familiares de Cáncer

Información personal

Nombre del paciente	Fecha de nacimiento	Proveedor de atención médica	Fecha de hoy

Instrucciones: Conocer sus antecedentes personales y familiares de cáncer es importante para poder brindarle la mejor atención posible. Complete el siguiente cuadro según sus antecedentes personales y familiares de cáncer. Deje el casillero en blanco cuando no sepa la respuesta.
Debe considerar a los siguientes familiares: Padres, hermanos, medio hermanos, hijos, abuelos, nietos, tías, tíos, sobrinas y sobrinos tanto por parte materna como paterna.

Tiene antecedentes personales de:	¿Sí (S) o No (N)?	¿Qué tipo de cáncer?	¿Edad al momento del diagnóstico?
Cáncer de mama, **de ovario** o **de páncreas** diagnosticado a cualquier edad	☐ S ☐ N		
Cáncer colorrectal o **de útero** diagnosticado a los 64 años de edad o antes	☐ S ☐ N		

Tiene antecedentes familiares de:	¿Sí (S) o No (N)?	¿Qué familiar?	¿Por parte materna (M) o paterna (P) de la familia?	¿Edad al momento del diagnóstico?
Cáncer de mama a los 49 años de edad o antes	☐ S ☐ N		☐ M ☐ P	
Dos **casos de cáncer de mama** (bilateral) en un familiar a cualquier edad	☐ S ☐ N		☐ M ☐ P	
Tres **casos de cáncer de mama** en familiares del mismo lado de la familia a cualquier edad	☐ S ☐ N		☐ M ☐ P	
Cáncer de ovario a cualquier edad	☐ S ☐ N		☐ M ☐ P	
Cáncer de páncreas a cualquier edad	☐ S ☐ N		☐ M ☐ P	
Cáncer de mama en hombres a cualquier edad	☐ S ☐ N		☐ M ☐ P	
Cáncer de próstata metastásico a cualquier edad	☐ S ☐ N		☐ M ☐ P	
Cáncer de colon a los 49 años de edad o antes	☐ S ☐ N		☐ M ☐ P	
Cáncer de útero a los 49 años de edad o antes	☐ S ☐ N		☐ M ☐ P	
Ascendencia judía asquenazí con **cáncer de mama** a cualquier edad	☐ S ☐ N		☐ M ☐ P	
Si tiene antecedentes familiares de algún **otro tipo de cáncer**, enumere aquí:				
¿Alguna vez se ha hecho usted o alguno de sus familiares una prueba genética para el cáncer hereditario?	☐ S ☐ N	¿Quién?	¿Qué gen(es)?	¿Cuál fue el resultado?

Revisión de la Evaluación del Riesgo de Cáncer (para completar después de hablar con el proveedor de atención médica)

Firma del paciente ______________________ Fecha __________

Firma del proveedor de atención médica ______________________ Fecha __________

Office Use Only (Para uso interno solamente) Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk®
☐ COLARIS®PLUS with Myriad myRisk® ☐ COLARIS AP®PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update
☐ Other: ______________________

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: ______________________