

Please Print

Social Security Number: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Address: \_\_\_\_\_

Marital Status:

- Single
- Married
- Other (Widow, Divorce, Separated)

(City) (State) (Zip Code)

Race: (Check One)

- American Indian/ Alaska Native
- Asian/Oriental
- Black/African American
- Middle Eastern/North African
- White
- Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_

Ethnicity: (Check One)

- Central American
- Cuban
- Dominican
- Hispanic
- South American
- Other: \_\_\_\_\_

Contact Preference:

Home Phone  Cell Phone  Work  Mail

Email: \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insurance Information:

(City) (State) (Zip Code)

Primary Insurance CO.: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Spouse's Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Patient:

Emergency Contact: \_\_\_\_\_  
(Phone Number)

- Spouse
- Parent/Guardian
- Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize N. M. KHAN M.D. S.C or insurance company to release any information required to process my claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Guardian Signature)

**N. M. KHAN M.D. S.C.  
Noorun M. Khan, MD  
7600 W. College Dr.  
Palos Heights, IL 60463  
708-671-1800**

### **Medical Information Privacy Notice**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY N. M. KHAN M.D. S.C. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Effective date: Date on patient's acknowledgement of HIPAA Notice.**

- 1. PURPOSE OF THIS NOTICE:** We consider any information that concerns your health, health care or payment for that care to be confidential and protected information. This notice describes our privacy practices; specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. WE require all of our employees, staff, volunteers and independent contractors to comply with these privacy practices.

**We are required by federal law to obtain an acknowledgement from you that you received this notice. Please sign the attached form and return it to the receptionist.**

**Please feel free to contact the privacy officer/receptionist to discuss, or request any additional information regarding any of our privacy practices or this notice.**

- 2. THE USE AND DISCLOSURE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.** By law we are allowed to use and disclose your medical information for most purposes related to your medical treatment(s), the payment for your medical treatment(s), and our health care operations or the operations of other covered entities to which we disclose your medical information.

Treatment means the provision, coordination or management of health care and related services by or involving one or more health care providers, such as the coordination of consultants and referrals. For example, we can share most medical information regarding your health condition with another provider as part of a consultation. We may also contact you to remind you to make, or that you already made, an appointment; to notify you regarding treatment alternatives or other health related benefits and services that may be of interest to you.

Please note that by law, certain medical information, such as psychotherapy notes, generally may not be used or shared even when it is related to your treatment, unless we obtain an authorization from you to use or release that information.

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**Acknowledgement of receipt of Privacy Notice**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge I have received your Privacy Notice containing a more complete description of the uses and disclosures of my health information.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.

Patient/Guardian or Personal Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient authorizes the release of information to the following family members or friends, please list the name of the person as well as a phone number where they can be reached:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Please list any surgeries or hospital stays you have had and their approximate year:		
Year	Type of surgery/reason for hospitalization	Location

Health Habits			
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Number of cigarettes each day?		
	For how many years?	If you quit what year did you quit?	
<b>Drugs</b>	Have you regularly used other drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you still using them?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check to indicate if you have ever had the following conditions:		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Arrhythmia
<input type="checkbox"/> Eye Problems-Type:	<input type="checkbox"/> Cancer-Type:	<input type="checkbox"/> Other:

**If you have any other medical problems or serious injuries that are not listed above, please describe them here:**

**FAMILY HEALTH HISTORY**

Condition	Who in your family has had or has this condition?	
Alcoholism or Drug Use		
Cancer		What type:
Diabetes		What type:
Heart Disease		
High Blood Pressure		
High Cholesterol		
Osteoporosis		
Mental Illness		
Stroke		
Thyroid Disease		
Other		