PATIENT DEMOGRAPHICS

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____

Patient Information

Name: _____ DOB: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip: _____
Home phone: _____
Work phone: _____ Sex: F M
Cell phone: _____
Email address: _____

Preferred language: □ English □ Spanish □ Other: _____

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino □ Unknown

Race: □ Black/African American □ White/Caucasian □ American Indian/Alaska Native
□ Asian □ Native Hawaiian/Pacific Islander □ Unknown
□ Other: _____

□ Married □ Single □ Divorced □ Widowed □ Partner

Spouse's name: _____ Phone: _____
Spouse's DOB: _____ Spouse's SSN: _____

In case of emergency, notify:

Name: _____ Phone: _____
Relationship: _____
City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance name: _____ Copay amount: _____
Relationship to patient: _____ Subscriber's name: _____
Subscriber ID/Contract Policy #:_____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer:_____ Employer's Phone: _____

Secondary Insurance name: _____ Copay amount: _____
Relationship to patient: _____ Subscriber's name: _____
Subscriber ID/Contract Policy #:_____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer:_____ Employer's Phone: _____

How did you hear about us? _____

HEALTH HISTORY

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____ Name: _____
DOB: _____ Reason for visit: _____
How would you rate your overall health: □ Excellent □ Good □ Fair □ Poor

MEDICAL HISTORY:	Self	Mother	Father	Brother	Sister
Acid Reflux	□	□	□	□	□
Anxiety	□	□	□	□	□
Arthritis	□	□	□	□	□
Cancer	□	□	□	□	□
COPD/Asthma	□	□	□	□	□
Depression	□	□	□	□	□
Diabetes	□	□	□	□	□
High cholesterol	□	□	□	□	□
High blood pressure	□	□	□	□	□
Kidney disease	□	□	□	□	□
Thyroid issues	□	□	□	□	□

Other _____

Tobacco Use: □ Never □ Current smoker □ Cigarettes □ Cigar □ Snuff □ Chew
□ Date started: _____ □ _____ packs/day □ _____ # of years
Alcohol Use: □ Yes □ No □ _____ # of drinks/day
Drug Use: □ Recreational drugs □ Injectable drugs
Caffeine: □ Never □ Occasional □ Frequent □ Excessive □ _____ cups per day
□ Soda □ Coffee □ Energy drinks
Exercise: Do you exercise regularly? □ Never □ Occasional □ Frequent □ Daily

Past Surgical History:

_____
_____
_____

Health Screenings:

□ Mammogram Date: _____ □ Colonoscopy Date: _____
□ PAP smear Date: _____ □ PSA/Prostate Date: _____
□ DEXA scan Date: _____

Immunizations:

□ COVID-19 vaccine Date: #1 _____ #2 _____ Booster _____
□ Flu vaccine Date (if known): _____
□ Pneumonia Date (if known): _____
□ Tetanus Date (if known): _____

Signature of patient/guardian _____ Date _____

ALLERGIES & MEDICATIONS

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____
Name: _____
DOB: _____

Allergies:

Allergy	Reaction	Severity

Current Medications:

Medication Name	Dosage (# of mg, etc.)	How many times per day

Signature of patient/guardian _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____

(PLEASE PRINT CLEARLY)"
Name: _____ DOB: _____
Social Security Number: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____

RELEASE MY MEDICAL RECORDS FROM:

Physician Name: _____
Business Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

SEND MY RECORDS TO:

Rakhshanda Abidi Khan, M.D.
401 Lowell Dr. SE, Suite 19
Huntsville, AL 35801

Phone: (256) 801-8649
Fax: (256) 270-8175

REASON:

Selected new physician in the area
Second opinion/Consult
Other: _____

Change in insurance
Moving out of town

PORTION OF RECORDS TO BE RELEASED:

Entire Medical Record

Other:

Restrictions: I understand that the recipient of this information may not use this information except for the express purpose identified above unless another authorization is obtained from me or unless such a disclosure is specifically required.

_____ _____

Patient/Parent/Guardian Signature

Date

_____

Patient Name Printed

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____
Name: _____
DOB: _____

I authorize the use or disclosure of the above named individual's health information as described below:

• Abidi Family Practice is authorized to make the disclosure.

• The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

…All/entire record

…Registration record
…X-ray and imaging reports
…EKG report
…Pathology report
…Consultation report
…Visit/encounter notes
…Immunization record
…Drug and alcohol treatment
…HIV/AIDS/STD treatment
…Operative report
…Other: _____

• This information may be disclosed to and used by the following individual or agency:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

• I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Abidi Family Practice. I understand the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

• Unless otherwise revoked, the authorization will expire on the following date, event or condition:

…Indefinitely …Specific Date _____

• I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

• I understand as the recipient, I am responsible for the security of these medical record copies and the health information contained therein.

• I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

_____ _____ _____
Signature Date Time

_____
Relationship to patient (if signed by legal representative)

_____ _____ _____
Signature of Witness Date Time

CREDIT CARD AUTHORIZATION
(Effective 02/01/2023)

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____

Patient Name: _____

Date of Birth: _____

CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff have access to the information.

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize Abidi Family Practice to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within thirty days after I receive a statement. I agree to receive billing statements, invoices, and receipts via the email I have provided to this office. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date

MISSED APPOINTMENT POLICY
(Effective 02/01/2023)

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____

Patient Name: _____

Date of Birth: _____

FOR ALL PATIENTS

In order to deliver quality care in a timely manner, we ask that you please provide our office a 24-hour notice for all cancellations. As a courtesy our office does make reminder calls 24-48 hours in advance. However, patients are responsible for keeping their appointments.

A **$50.00 Missed Appt fee** will be charged to your account if a 24-hour notice is not provided. This does include **same day** cancellations. We understand that situations may arise that prevent you from making your appointment, but repeated occurrences may be cause for dismissal from our care.

In signing this form you are acknowledging that you have read and understand this policy.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Patient Name Printed

01/01/2023

NON-COVERED SERVICES WAIVER

Abidi Family Practice
Rakhshanda Abidi Khan, M.D.

Date: _____

Patient Name: _____

Date of Birth: _____

There are services for which your health plan may not cover. Health plans do no pay for ALL of your health care costs, but only pays for covered benefits of that individual plan. When this occurs, you will be responsible for payment of these non-covered services. Our billing office will send an invoice and payment will be due at that time.

By voluntarily signing this Non-Covered Services/Waiver form you agree to be financially responsible to Rakshanda Khan, M.D./Abidi Family Practice for the full amount that is not covered by your health plan as well as make payment in a timely manner.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Patient Name Printed

3/22/2022