ABIDI FAMILY PRACTICE
RAKHSHANDA ABIDI KHAN, M.D.

Date : _____

PATIENT DEMOGRAPHICS

PATIENT INFORMATION

First Name: _____ Last Name: _____ Gender: ◯ Male ◯ Female

DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____

Mobile phone: _____ Home phone: _____ Work phone: _____

Primary Number : ◯ Mobile ◯ Home ◯ Work

Preferred Pharmacy Name & Address: _____

City: _____ State: _____ ZIP: _____

Preferred Lab: _____ City: _____ State: _____ ZIP: _____

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: _____

In case of emergency, notify:

Name: _____ Phone: _____

Relationship: _____

City: _____ State: _____ ZIP: _____

Martial Status

◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Partner

Spouse's Name: _____ Phone: _____

Spouse's DOB: _____ Spouse's SSN: _____

Insurance Information

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Secondary Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

How did you hear about us?

◯ Insurance Company ◯ Patient in Practice: _____
◯ Specalist Physician ◯ Other: _____

ABIDI FAMILY PRACTICE

RAKHSHANDA ABIDI KHAN, M.D.

Date: _____

Name: _____ DOB: _____

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	○	○	○	○	○
Thyroid Issues	○	○	○	○	○
Kidney Disease	○	○	○	○	○

Tobacco Use: ○ Never ○ Current smoker ○ Cigarettes ○ Cigar ○ Snuff ○ Chew ○ Vape

○ 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 or _____ times per week

Past Surgical History:

_____

_____

_____

Health Screenings:

○ Mammogram Date: _____

○ Diabetic Eye Exam Date: _____

○ Colonoscopy Date: _____

○ DEXA scan Date: _____

○ PAP smear Date: _____

Immunizations: ○ COVID-19 vaccine Date: #1 _____ #2 _____ Booster _____

○ Flu vaccine Date (*if known*): _____

○ Pneumonia Date (*if known*): _____

○ T-Dap Date (*if known*): _____

Signature of patient/guardian _____ Date _____

ABIDI FAMILY PRACTICE
RAKHSHANDA ABIDI KHAN, M.D.

ALLERGIES & MEDICATIONS

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 _____

ABIDI FAMILY PRACTICE
RAKHSHANDA ABIDI KHAN, M.D.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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:
(Select all that apply & include dates where appropriate)

- ○ *All/Entire record*
- ○ *Registration record*
- ○ *X-ray and imagining 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: _____ Phone:_____
Name: _____ Relationship: _____ Phone:_____
Name: _____ Relationship: _____ Phone:_____
Name: _____ Relationship: _____ Phone:_____

• 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

ABIDI FAMILY PRACTICE
RAKHSHANDA ABIDI KHAN, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date:_____

(PLEASE PRINT CLEARLY)

(MM/DD/YYYY)

Name: _____ DOB: ____/_____/_____

Social Security Number: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

RELEASE MY MEDICAL RECORDS FROM:

Physician Name: _____

Business Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

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 ○ Change in insurance
○ Second opinion/Consult ○ Moving out of town

○ Other: _____

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

ABIDI FAMILY PRACTICE
RAKHSHANDA ABIDI KHAN, M.D.

CREDIT CARD AUTHORIZATION
(Effective 02/01/2023)

Date: _____
Name: _____
DOB: _____

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.

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.

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

City: _____ State: _____ ZIP: _____

_____ _____
Patient/Parent/Guardian Signature Date

_____
Patient Name Printed

ABIDI FAMILY PRACTICE
RAKHSHANDA ABIDI KHAN, M.D.

Missed Appointment Policy
(Effective 01/01/2025)

Date: _____
Name: _____
DOB: _____

FOR ALL PATIENTS

In order to deliver quality care in a timely manner, we ask that you please provide our office with at least **1 business day** notice for **all** cancellations. Our office does make courtesy calls 24-48 hours in advance.

- For General follow-up Appointments: $59.00
- For Annual Physical Appointments: $79.00
- For Establish of Care (*New Patient*) Appointments: $99.00

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