EXECUTIVE
PLASTIC SURGERY

NEW PATIENT INTAKE FORM Today's Date: _____ Chart Number: _____

Patient Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Home Phone: (_____) _____ Cell: (_____) _____

Email Address: _____ Sex: F M Marital Status: Married Divorced Single

Emergency Contact: _____ Phone #: (_____) _____

Employer Name: _____ Employer Phone: (_____) _____

Employer Address: _____ Job Title: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____

Insurance ID#: _____

Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber SS#: _____

Subscriber Employer: _____

Relationship to Patient: _____

Secondary Insurance: _____

Insurance ID#: _____

Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber SS#: _____

Subscriber Employer: _____

Relationship to Patient: _____

Is this work related? _____ No _____ Yes, Date of Injury: _____

Work Comp Contact: _____

Is this a motor vehicle accident? _____ No _____ Yes, Date of Accident: _____ Which state: _____

Auto Carrier Contact: _____

Attorney: ____ No _____ Yes, Attorney Name: _____ Attorney Phone: (_____) _____

Breast Implant Illness Onset Date (when did your symptoms/problems start)? _____

How did you hear about Dr. Khan:

☐ Friend/Relative ☐ Facebook ☐ YouTube ☐ Instagram ☐ TikTok ☐ Google ☐ Website

Please provide details:

☐ TV/News _____ ☐ Radio _____ ☐ Podcast _____ ☐ Other _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL DOCUMENTATION & CLAIM PAYMENT INFORMATION:
I hereby authorize Dr. Shaher Khan to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file an insurance claim. I hereby authorize and direct payment for benefits due to me for the services rendered by Dr. Shaher Khan to be made directly to him. I understand the physician's charges may exceed my insurance carrier's payment and if greater than such payment, I will be responsible for that amount and any charges rejected by my insurance company. I fully agree that the insurance information provided to Dr. Shaher Khan is the correct insurance and I am responsible for the total amount not covered by this insurance carrier. Reasonable attorney fees and interest if the matter is not paid by the carrier or paid by the patient timely. A charge of $25.00 applies for any disability paperwork to be completed and payment is required upon delivery of forms and before completion of forms. Please allow 7 business days for all forms to be completed. Also, by signing below, I acknowledge that I have been offered a copy of this office's notice of privacy practices form and that I have either received or rejected that offer.

PHOTOGRAPHIC AUTHORIZATION:
I consent to the taking of photographs or videotapes of myself or parts of my body by Executive Plastic Surgery, PLLC., in connection with any and/or all plastic surgery procedure(s) to be performed by Dr. Shaher Khan. I understand that photographs may be required by my insurance company for the purpose of prior authorization and consent to the release of any requested images for this purpose. I understand that such photographs, videotapes, or case histories may be published by Dr. Shaher Khan and/or any party acting under his license and authority with Executive Plastic Surgery, PLLC. in any print, visual or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and internet websites, for the purpose of informing the medical profession or the public about plastic surgery methods. Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that shall make my identity recognizable. I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty (20) years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Executive Plastic Surgery, PLLC. I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I release and discharge Dr. Shaher Khan and Executive Plastic Surgery, PLLC. including all parties acting under his license and authority from all rights that I may have in the photographs, videotapes, or case histories and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

PATIENT PARTNERSHIP PLAN:
Welcome to Executive Plastic Surgery, PLLC. We hope to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health", we ask you to participate in your care in the following ways: I WILL KEEP FOLLOW-UP APPOINTMENTS AND RESCHEDULE MISSED APPOINTMENTS. I understand that Dr. Khan and his clinical staff will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. All labs/specimens are sent out to St. John/Ascension Health/JVHL for processing. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. I WILL CALL THE OFFICE WHEN I DO NOT HEAR THE RESULTS OF LABS AND OTHER TESTS. I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results. I WILL INFORM MY DOCTOR IF I DECIDE NOT TO FOLLOW HIS RECOMMENDED TREATMENT PLAN. I understand that after examining me, my doctor may make certain recommendations that are based on what he feels are best for my health. This might include prescribing medication, referring me to another specialist, ordering labs and tests, or even asking me to return to the office within a certain period. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment. Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, seek an explanation, report symptoms, or discuss concerns. If you need more information about your health or condition, please ask.

NOTICE OF PRIVACY PRACTICES:
At Executive Plastic Surgery, PLLC., your privacy is a very important part of our mission and plays a very big factor in your experience. Dr. Khan and his staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your healthcare information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPAA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003. As of April 14th, 2003, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI). Your PHI, also known as your health or medical record, serves as a:
• Basis for planning your care and treatment
• Means of communication among the many health professionals who contribute to your care
• Legal document describing the care you received
• Means by which you or a third-party payer can verify that services billed were provided
• A tool in educating health professionals, a source of data for medical research
• A source of information for public health officials charged with improving the health of this state and the nation
• A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
The "Notice of Privacy Practices" details the following:
• How we may use/disclose your PHI to carry out treatment, payment, or health care operations.
• How you may request copies of your healthcare information. How you may verify the accuracy of this information.
• How you may request an accounting of certain external disclosures of your PHI.
I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below: "I have been offered a Notice of Privacy Practices by the office of Shaher W. Khan, M.D of Executive Plastic Surgery, PLLC. I fully understand and accept the terms of this consent."

ASSIGNMENT OF RIGHTS/BENEFITS:
Assignee is a medical provider that has provided medical treatment, products, services and/or accommodations ("Services") to Assignor. Assignor acknowledges that he/she has received Services from Assignee and that Assignor has incurred charges for such Services. Assignor hereby certifies that upon execution of this agreement all such charges with respect to Services rendered to Assignor by Assignee occurred on or before the date of execution of this agreement, and the rights, privileges, and remedies for payment for each of those Services are hereby assigned to Assignee. Assignor understands this Assignment is effective as of today's date and applies to all of Assignor's rights to recover payment for all past and present Services rendered to Assignee by Assignee, and in furtherance of the Assignment, Assignor acknowledges the following: This is an assignment of the right to recover payment of charges incurred for Services, for which charges are payable under any policy of insurance, contract and/or statute. Such assignment shall include, in Assignee's sole discretion, the right to pursue appeal of a payment denial under any procedure outlined in any insurance policy, contract or statute and/or the right to file a lawsuit to enforce the payment of benefits due or past due for the Services incurred and resulting charges. For all purposes of enforcement of this Assignment, the Assignee or its agent is designated as my attorney in fact with respect to any action taken in pursuit of payment for Services provided by Assignee. Assignor and Assignee agree that as consideration for this assignment, Assignee assumes the burden, otherwise born by the Assignor, to pursue payment for Services rendered by the Assignee, from the insurance company or entity responsible to pay for such Services. This may include Assignee doing some or all of the following: (1) submitting its bills directly to the insurance company or entity; (2) pursuing the insurance company or entity which is responsible to pay Assignee's bills for payment of Assignee's bills; (3) incurring any expense associated with pursuing payment of Assignee's bills, (4) hiring or retaining the services of an attorney or collection agency to pursue payment of Assignee's bills. Furthermore, Assignee hereby grants Assignor a lien in the amount of all charges for Services that have been rendered and have been incurred by me for medical care provided by Assignee, and any of its physicians. This lien shall apply to proceeds acquired through the exercise of any rights arising from any claim, recovery, judgment, settlement or adjudication of any claim made by or available to me against any individual or insurance company which gave rise to the medical services provided. I further instruct my attorney(s), _____, to treat the medical bill for Services incurred by me from Assignee as a first lien upon any monies recovered, from whatever source, disclaiming any common fund, and to pay the amount of the lien in full, without regard to any costs or attorney fees that I may incur. I further instruct my attorneys to advise Assignee as to the existence of any claim asserted on my behalf relating to the medical services provided, so that Assignee may seek its own counsel and representation to enforce this Assignment of Rights and Medical Lien. I understand that notwithstanding anything to the contrary contained herein or elsewhere I remain personally responsible to pay for the Services rendered to me by the Assignee and I agree to pay the full amount of Assignee's invoices for the Services upon demand. Unless mutually agreed to in writing, the receipt and processing of partial payments shall not constitute a waiver of the Assignee's right to receive payment in full upon demand, irrespective of any restrictions indicated on any payments. I understand that I can request a copy of my total charges for Services rendered by the Assignee. I understand that any settlement amount received by me from any source may not be enough to pay Assignee, in whole or in part, for the Services rendered. This assignment shall be irrevocable unless terminated by mutual agreement of Assignee and Assignor in writing. Assignor and Assignee agree that in the event any terms or provisions agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect and such court shall interpret and reform such invalid and unenforceable provision, if able, to make such provisions enforceable and carry out the spirit and intent of the parties.

(Assignee) PATIENT SIGNATURE: _____DATE: _____

(Assignee) PARENT/GUARDIAN IF MINOR/ SIGNATURE: _____DATE: _____
RELATIONSHIP TO PATIENT: _____

(Assignor) EXECUTIVE PLASTIC SURGERY, PLLC., SHAHER W. KHAN, M.D.

BREAST IMPLANT QUESTIONS:

What type of implant(s) do you currently have:
_____ N/A
_____ Saline
_____ Silicone
_____ Unknown

How were your implant(s) placed:
_____ Above the muscle
_____ Below the muscle
_____ Unknown

What is the surface of your implant(s):
_____ Smooth
_____ Textured
_____ Polyurethane
_____ Unknown

How many sets of implants have you had:
_____ 1
_____ 2
_____ 3
_____ 4

What size are your implant(s):
_____cc Right
_____cc Left
_____ current bra size if unknown

Are your *CURRENT* implant(s) ruptured:
_____ Yes, right
_____ Yes, left
_____ No
_____ Unknown

Were any of your *PREVIOUS* implant(s) ruptured:
_____ Yes, right
_____ Yes, left
_____ No
_____ Unknown

What is the brand of your implant(s):
_____ Allergan
_____ McGhan
_____ Mentor
_____ Sientra
_____ Other

Did you have Alloderm/Dermal Matrix placed when you augmented:
_____ Yes, Alloderm
_____ Yes, Dermal Matrix
_____ No
_____ Unknown

What physician did your augmentation:
Dr. _____

City/State: _____

How old is your *CURRENT* set of implants:
_____ Years old
_____ N/A

What was your original bra size prior to implant(s):
_____ Band size (chest)
_____ Bust size (cup)
What year did you get your implant(s):
_____ 1st set
_____ 2nd set
_____ 3rd set
_____ 4th set

Have you had any recent testing and when:
Year: _____ MRI
Year: _____ Mammogram
Year: _____ Ultrasound
Year: _____ Other

BREAST CANCER QUESTIONS:

Do you have a history of breast cancer:
_____ Right breast
_____ Left breast
_____ Both breasts
_____ N/A

What treatment did you have for the breast cancer:
_____ Chemotherapy
_____ Radiation
_____ Lumpectomy
_____ Reconstruction
_____ Mastectomy
_____ N/A

Have you been tested for the BRCA gene:
_____ Yes, BRCA gene ***positive***
_____ Yes, BRCA gene ***negative***
_____ No

Do anyone in your family have a history of breast cancer:
_____ Yes, relation: _____
_____ No
_____ Unknown

SOCIAL QUESTIONS:

Do you currently smoke:
_____ Yes
_____ No
_____ Previous tobacco user _____ years
_____ How many packs per day _____
_____ How long have you smoked _____
_____ cigarettes _____ pipe _____ chew tobacco

Do you use or have you used recreational drugs:
_____ Yes
_____ No
_____ Marijuana _____ Edibles _____ Vape
_____ Other _____
_____ How much and how often:
_____

Do you consume alcohol:
_____ Yes: _____ beer _____ wine _____ liquor
_____ No
_____ Daily
_____ Occasionally (3-10 month)
_____ Socially (1-3 month)

Do you consume caffeine:
____ Yes
____ No
_____ How much and how often
_____

ANESTHESIA QUESTIONS:

Have you ever had any problems with anesthesia, narcotics, or sedation:
_____ Yes (please explain) _____
_____ No

Do you have any family history of problems related to anesthesia:
_____ Yes (please explain) _____
_____ No

Do you or an immediate blood relative have or are aware of having malignant hyperthermia (MH)?
_____ Yes (please explain) _____
_____ No

Are you familiar with the signs and symptoms of malignant hyperthermia (MH)?
_____ Yes (please explain) _____
_____ No

Have you ever had an adverse reaction to a muscle relaxant during administration of anesthesia?
_____ Yes (please explain) _____
_____ No

Have you ever had muscle stiffness during administration of anesthesia?
_____ Yes (please explain) _____
_____ No

Have you ever had a high fever over 104 degrees, rapid breathing, or fast heart rate during or after administration of anesthesia?
_____ Yes (please explain) _____
_____ No

Do you have any sleeping disorders such as sleep apnea or use a CPAP machine:
_____ Yes (please explain) _____
_____ No

Do you have any chance of pregnancy:
_____ Yes
_____ No, I have had a hysterectomy or tubal ligation
_____ Other: _____

Are you still menstruating:
_____ Yes
_____ No

Do you have any of the following:
_____ Hepatitis: A _____ B _____ C _____
_____ HIV Virus _____ AIDS _____
_____ STD's: _____

HEAD:

Do you (now or ever) have any problems with a history of migraines, headaches, dizziness, or vertigo:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

Have you ever had a stroke:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

HEART:

Do you have any of the following:
_____ Pacemaker
_____ Stent(s)
_____ Replacement valve

Do you (now or ever) have any problems with your heart or heart rhythm such as atrial fibrillation or heart attack:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

Do you (now or ever) have any problems with your blood pressure (high or low):
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

Do you (now or ever) have any problems with anemia, bleeding complications or clotting:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

LUNGS:

Do you (now or ever) have any problems with a serious upper respiratory/lung issue or asthma:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

INFECTIONS:

Do you (now or ever) have any problems with infections which required antibiotics:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

STOMACH:

Have you had a recent colonoscopy:
_____ Yes, date: _____
_____ No

Do you (now or ever) have any problems with vomiting, diarrhea, constipation, chewing or swallowing:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

Do you (now or ever) have any problems with your kidneys such as kidney stones, bladder infections, dialysis, UTI or interstitial cysts:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

ENDOCRINE:

Are you diabetic:
_____ Yes
_____ Type 1 ____ Type 2 ____
_____ Insulin dependent
_____ No

Do you (now or ever) have any problems with your thyroid or having high/low blood sugars:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

AUTOIMMUNE:

Do you (now or ever) been diagnosed with immune system problems such as lupus, rheumatoid arthritis, etc.:
_____ Yes (provide date and please explain)
_____
_____
_____
_____
_____ No

Have you had any significant weight gain/loss over the past several months:
_____ Yes (please explain below)
_____ No
_____

PRIMARY CARE PHYSICIAN:

Name: _____

Address:_____
_____
_____

Phone: ( ) _____ Fax: ( ) _____

SPECIALISTS:

Do you see any specialists: (list physician name and phone number for each)
_____ Cardiologist _____

_____ Endocrinologist _____

_____ Gastroenterologist _____

_____ Infectious Disease _____

_____ Nephrologist _____

_____ Neurologist _____

_____ Oncologist _____

_____ Psychiatrist _____

_____ Pulmonologist _____

_____ Rheumatologist _____

_____ Internal Medicine _____

Height: _____ ft ____ in **Weight**: _____lbs. **BMI**: _____

PRIOR TO IMPLANTS, DID YOU HAVE ANY HEALTH ISSUES?

_____ No
_____ Yes, please list
_____
_____
_____
_____
_____
_____
_____
_____

SINCE YOU HAVE HAD BREAST IMPLANTS, WHAT NEW ISSUES DO YOU HAVE?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY (include the year)

PAST SURGICAL HISTORY (include the year)

DRUG/MEDICATION ALLERGIES (include the reaction)

LATEX ALLERGY ☐ **YES** ☐ **NO**

MEDICATION/SUPPLEMENT/VITAMIN/HERB (include dose/strength/frequency)	**WEIGHT LOSS MEDICATIONS** (orally or injectable)
	Semaglutide (Wegovy, Ozempic)
	Tirzepatide (Zepbound, Mounjaro)
	Liraglutide (Saxenda)
	Phentermine (Adipex, Suprenza)
	Phentermine-topiramate (Qsymia)
	Naltrexone-bupropion (Contrave)
	Setmelanotide (Imcivree)
	Orlistat (Xenical and Alli)
	Have you taken any of these in the past 2 weeks? ___Yes ___No

PHYSICAL EXAM (physician use only)

LIFESTYLE QUESTIONS:

Are you able to exercise routinely:
_____ Yes (please explain below: type and how often)
_____
_____
_____
_____ No

Do you wear glasses, contacts, hearing aids:
_____ Yes: ___ glasses ___ contacts ___ hearing aid
_____ No

Do you have dentures (upper/lower/partial), caps, crowns, braces, veneers, loose or broken teeth:
_____ Yes, list:
_____
_____
_____ No

Do you have any metal anywhere in your body (pins, plates, screws, surgical/aneurysm clips, posts, defibrillator, pacemaker or insulin pump:
_____ Yes, list:
_____
_____
_____ No

Do you have any devices to help you ambulate:
_____ Cane
_____ Walker
_____ Wheelchair
_____ Other
_____
_____

Do you have a Living Will, Power of Attorney or Advanced Directives:
_____ Yes (please explain below)
_____
_____
_____
_____ No

Do you have any cultural/religious practices that may influence your medical care:
_____ Yes (please explain below)
_____ No
_____ Other:
_____
_____

Do you have any history of falls:
_____ Yes (please explain below)
_____
_____
_____
_____ No

Do you have any problems with completing your daily activities of living such as bathing, dressing, eating, etc.:
_____ Yes (please explain below)
_____
_____
_____
_____ No

Do you have any dietary restrictions and/or food sensitivities:
_____ Yes (please explain below what and how often)
_____
_____
_____
_____ No

Do you have any chronic pain:
_____ Yes (please explain where it is located, what you do to relieve it)
_____
_____
_____
_____ No
_____ Rate the pain: 0-10 being worst _____

Have you had any recent admissions to the hospital or ER visits in the past year:
_____ Yes (please explain below)
_____
_____
_____
_____ No

Are you having anxiety concerning your surgery:
_____ Yes (please explain)
_____
_____
_____
_____
_____ No

How do you typically deal with stress in your life:
_____
_____
_____
_____

ACCOMMODATIONS AFTER SURGERY:

Who will be helping you after surgery while you're here in Michigan:
_____
_____

Who do you wish to be your contact person on the day of your surgery:
_____
_____

Their relation to you: _____

Their contact number: _____

Where will you be staying in Michigan:
_____
_____

How will you be traveling to Michigan:
_____ Flying _____ Driving _____ Other

How many days do you plan on staying in Michigan *after* your surgery:
_____

What will be your mode of transportation while in Michigan:
_____ Personal car _____ Hotel shuttle
_____ Rental Car _____ Taxi/private service
_____ Uber/Lyft

PLEASE COMPLETE AND RETURN THIS FORM IN ITS ENTIRETY AS SOON AS POSSIBLE TO:
support@executiveplasticsurgery.com or fax to (248) 934-2185
Office Phone: (734) 419-1615
Thank you, Dr. Shaher W. Khan M.D.

Dr. Shaher W. Khan M.D.
Board Certified Plastic Surgeon
Board Certified General Surgeon

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