Health and Mind, LLC/
Tasneem Khan MD
1555 Post Rd E suite 201A
Westport, CT 06880

PATIENT INFORMATION FORM

Date: _____

Name: _____ **DOB:** _____ **Age:** _____

Sex: __ M __ F __ other Marital Status: __ S __ M __ D __ W SS # : _____ ____ ____

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Preferred Phone #: ( ) _____ Alternate Phone #: ( ) _____

E-mail: _____ **@ .com Employer:** _____

Emergency Contact: _____ **Relationship:** _____

Preferred Phone # : _____ **Alternate Phone #** _____

Primary Care Physician: _____ **Phone #:** ( ) _____

PRIMARY INSURANCE NAME: _____ **ID #**: _____

Group #: _____ **Policyholder Name:** _____

Relationship to the insured : _____

Referral source: _____

- Please provide a copy of your insurance card and your ID. Initials: _____
- Co- pay is collected on each visit at the time of check-in. Initials: _____
- A $ 50 no show fee is charged for no shows and if the appointment is not cancelled or rescheduled 24 hours prior to the appointment. Initials: _____
- A $30 fee will be charged for returned checks. Initials: _____
- A credit card on file is required. We charge $100 for new patients. This can be used for your copay and deductible. This will be your no show fee if you don't keep your initial appointment and do not give at least 72 hour notice for cancellation. Initials: _____

Patient's Signature: _____ **Date:** _____