REGISTRATION FORM

(Please Print)

Today's Date: ____________ Have you been a patient here before: ❑ Yes ❑ No How would you like to be addressed by our staff?	Primary Care Physician: Address: Phone #: ( ) Fax #: ( )

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home address:	City:	State: ZIP Code:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

P.O. Box:	Driver's License Number:	Social Security Number:	Home phone #: ( )

Mailing address: (if different from above)	City:	State: ZIP Code:	Mobile #: ( )

Occupation:	Employer:	Employer phone #: ( )	❑ Full-time ❑ Part-time ❑ Retired ❑ Other

Referred by (please check one box): ❑ Family ❑ Friend ❑ Doctor ❑ RN ❑ Other

Referring Doctor's Name:	Address:	Phone Number: ( )

INSURANCE INFORMATION

Please indicate primary insurance:	Address & Phone #:	Subscriber's Name:	Subscriber's S.S. #:

Birth Date: / /	Group #:	Policy #:	Co-payment: $	Subscriber's Occupation: Employer: Employer's Address: Phone #: ( )
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Other				

Name of secondary insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Other Subscribers S.S. # DOB:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Cell phone #: ( )

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

______________________________ ______________________________
Patient/Guardian signature *Date*

PATIENT HISTORY

All information contained within this questionnaire is strictly confidential.

Date: ______________________

Name: ____

Last First

Reason for Consultation: ____

____

Name of Referring Physician: ____

Specialty: ____

Address: ____

____

Telephone: ____

Fax: ____

HEALTH HISTORY

Age: ______________ **Height**: ______________ **Weight**: ______________

Current weight is: __________ Low __________ Normal __________ High

Past Medical History (e.g. Hypertension, Diabetes, Coronary Artery Disease, etc.): __________________________

____

____

Past Surgical History (including date): ____

____

____

Patient Name:____

Previous Plastic Surgery: Yes________ No________

Facelift: ______________________ Date:______________________

Rhinoplasty: __________________ Date: ______________________

Browlift: ______________________ Date: ______________________

Eyelids:_______________________ Date: ______________________

Upper ________ Lower ________ Both ________

Chemical Peel: ________________ Date: ______________________

Laser Peel: ___________________ Date: ______________________

Abdominoplasty: _____________ Date: ______________________

Breast Augmentation:_________ Date: ______________________

Saline ________ Silicone ________

Breast Reduction/Lift:________ Date: ______________________

Liposuction: __________________ Date: ______________________

Fat Injections: _______________ Date: ______________________

Botox: ________________________ Date of Last Injection: ______________________

Restylane: ____________________ Date of Last Injection: ______________________

Drug Allergies:____

____

No Known Drug Allergies (Circle if applies)

Current Medications (include Vitamins, Oral Contraceptives, Supplements, and Homeopathic Medications):

1) ____ 4) ____
2) ____ 5) ____
3) ____ 6) ____

Have you ever used Accutane? Yes __________ No_________ If yes, when was last dose? __________________

Smoking History: _____________ Never Smoked
_____________ Currently smoking (_______ packs per day)
_____________ Quit smoking (_______ years/months ago)
_____________ Nicotine patch

Patient Name:____

Alcohol Use: Yes________ No ________

If yes, amount per week:____

Number of Pregnancies:_______________ **Number of Children**: ________________

Personal History of Breast Cancer: ____________________

Family History of Breast Cancer: ______________________

If yes, who & age at diagnosis: Mother___________ Sister(s)___________ Aunt(s)___________

Last Mammogram (Date): ____________________ **Location:**_________________________________

Have You Ever Had Visual Problems? Yes_____ No _____

Do You Wear Glasses or Contact Lenses? Yes_____ No_______

Do You Have Dry Eyes? Yes_____ No _____

Have You Had Corrective Eye Surgery? (e.g. Lasik): Yes_____ No _____

Last Eye Examination: _______________________ **By Whom?**_______________________

Have You Ever Had a Problem with Anesthesia? Yes_____ No _____

If Yes, Explain: ____

Have You Ever Had a Blood Transfusion? Yes_____ No _____

REVIEW OF SYSTEMS

Check all that apply. If yes, briefly explain in space provided.

General (appetite, sleeping habits, fatigue, weakness, fever): Yes_____ No_____

____

Skin (rashes, sores, bruising, hair loss, itching, lesions, acne, keloids): Yes_____ No _____

____

HEENT (migraines, hearing changes, nose bleeds, sore throat, hoarseness, sinus problems): Yes_____ No_____

____

Breasts (pain, discharge, enlargement, lumps): Yes_____ No_____

____

Respiratory (shortness of breath, asthma, cough, TB, COPD, pain): Yes_____ No _____

____

Cardiovascular (angina, palpitations, arrhythmias, edema, hypertension, murmur): Yes_____ No _____

____

Gastrointestinal (nausea, vomiting, jaundice, diarrhea, constipation, bloody stools, abdominal pain): Yes____ No _____

____

Genitourinary (bloody urine, pain on urination, stones, urinary infections, increased urinary frequency): Yes____ No _____

____

OB/GYN (pain on menstruation, discharge, infection, intermenstrual bleeding, menopause): Yes____ No____

____

Musculoskeletal (arthritis, fractures, dislocations, weakness): Yes ____ No ____

____

Neurologic (vertigo, headaches, syncope, seizures, paralysis, loss of memory, stroke, numbness): Yes_____ No _____

____

Hematologic (bleeding, easy bruising, swollen lymph nodes, recurrent infections): Yes_____ No _____

____

Endocrine (thyroid, obesity, gynecomastia, hot/cold intolerance, nervousness): Yes _____ No_____

____

Psychiatric (depression, anxiety, suicide ideation, hallucinations): Yes_____ No_____

____

Patient Name:____

FAMILY HISTORY

Family Member	Age	Alive/Deceased	Medical Conditions
Mother			
Father			
Sister(s)			
Brother(s)			

I certify that the above information is true and accurate. I realize that any omissions or false information may negatively impact the outcome of my surgery and/or result in serious adverse medical consequences.

______________________________ Signature of Patient

______________________ Date

5363 Balboa Boulevard
Suite 100
Encino, CA 91316

23929 McBean Parkway
Suite 110
Valencia, CA 91355

CBCC-The Breast Center
6501 Truxton Avenue
Bakersfield, CA 93309

1560 E. Chevy Chase Drive
Suite 255
Glendale, CA 91316

Phone: 818-241-9611 **Fax**: 818-302-1699

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient with Insurance:
As a courtesy to patients with private healthcare insurance, we will complete and file claims with the appropriate insurance companies provided all necessary information is obtained and deductibles are met. All patients are kindly requested to understand that financial responsibility for physician services still remains theirs, the patients, – and not their insurance companies. Even though an insurance claim is filed on the patient's behalf, this office cannot accept responsibility for collection of the claim nor can it get involved in negotiating settlement on a disputed claim. Payment of our fees is at all times the sole responsibility of the patient.

Patient with Medicare:
It is the policy of this office to "accept assignment" on all claims submitted to Medicare on behalf of our patients. This means that we will file a claim with Medicare on the patient's behalf and look for payment directly from Medicare for 80% of the allowable fees. We will then bill the patient's secondary insurance or the patient directly if there is no secondary insurance.

Financial Responsibility:
I, the undersigned, do hereby assume full responsibility for the payment of the services rendered to this patient. Furthermore, I assign my insurance benefits, in connection with all services, rendered, to Peter H. Ashjian, M.D. I understand that I shall be responsible for any service, which is not covered in part, or as a whole by insurance. Should the account be referred to a professional collection agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. The undersigned certifies that he/she has read the foregoing, and has received a copy thereof and furthermore attests that he/she is either the patient or an authorized representative of the patient to execute this form and accept its terms.

______________________________ ______________________________
Patient Patient's Agent or Representative

______________________________ ______________________________
Witness Relationship to Patient

____
Date

PETER H. ASHJIAN, M.D.
PLASTIC & RECONSTRUCTIVE SURGERY

5363 Balboa Blvd	23929 McBean Parkway	CBCC-The Breast Center	1560 E. Chevy Chase Dr.
Suite 100	Suite 110	6501 Truxton Avenue	Suite 255
Encino, CA 91316	Valencia, CA 91355	Bakersfield, CA 93309	Glendale, CA 91206

Phone: 818-241-9611 Fax: 818-302-1699

CONSENT FOR MEDICAL PHOTOGRAPHY, TELEVISION, OR VIDEOTAPE RECORDING

(Please initial all paragraphs that you agree to participate in)

Dear Patient,

Dr. Peter Ashjian often takes pre-operative, intra-operative, and post-operative photographs of patients to help him provide the best care possible for you. These photographs are very useful for planning your surgery and evaluating the outcome of your procedure. We respect your privacy and will only take these photographs or videotape with your express consent. In addition to using these photographs or videotape for your own medical care, Dr. Peter Ashjian often gives lectures to patient groups and to physicians at national meetings. In these settings, the photographs or videotape would be used for educational purposes. We wish to obtain your express consent for these applications as well. Sometimes these photographs or videotape are used in print or television media as well. We will only do this if you choose to give your consent for this purpose. We have very clear guidelines for how we take these photographs.

Consent to take Photographs or Videotape (please initial blank at beginning of paragraph)

___ I, the undersigned, do hereby consent and agree that Dr. Peter Ashjian, his employees, or assistants have permission to take photographs or videotape of me beginning on the first day that I am seen in consultation. This also includes permission to take additional photographs or videotape of my body in the operating room while I am under anesthesia as well as additional photographs or videotape in the office during post operative follow-up visits.

Consent for Use of Photographs or Videotape for Education and Research (please initial)

___ I, the undersigned, do hereby consent and agree that Dr. Peter Ashjian may use these photographs or videotape in any and all media, now or hereafter known, and exclusively for the purpose of patient education, physician education, and research. I further consent that my photographs may be used without my name being mentioned in a descriptive text or commentary. I do hereby release to Dr. Peter Ashjian, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback. I also understand that Dr. Peter Ashjian is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

Consent for Use of Photographs in Print, Internet, or TV Media (please initial)

___ I, the undersigned, do hereby consent and agree that Dr. Peter Ashjian may use these photographs or videotape in any and all media, now or hereafter known, in printed media such as magazine or newspapers, in video media such as television, or in internet media. I further consent that my photographs may be used without my name being mentioned in a descriptive text or commentary. I do hereby release to Dr. Peter Ashjian, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback. I also understand that Dr. Peter Ashjian is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Signature: ______________________________ Name: ____

Date: _________________________________ Witness: ____

PETER H. ASHJIAN, M.D.
PLASTIC & RECONSTRUCTIVE SURGERY
1560 EAST CHEVY CHASE DR. SUITE 255 GLENDALE, CA 91206
T 818.241.9611 F 818.302.1699 www.PeterAshjian.com

Acknowledgement of Receiving Notice of Privacy Practices

Glendale
1560 East Chevy Chase Dr. Suite 255
Glendale, CA 91206

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Valencia, CA 91355

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5363 Balboa Blvd, Suite 100
Encino, CA 91316

Bakersfield – CBCC Breast Center
6501 Truxtun Ave
Bakersfield, CA 93309

Office: (818) 241.9611 Fax: (818) 302.1699

I, ____
received and understand the Notice of Privacy Practices.

____ ______________
Patient Signature Date

This notice has been given to you separately. It is five pages: NOTICE OF PRIVACY PRACTICES.
Your signature on this page is your acknowledgement of receiving it.

PETER H. ASHJIAN, M.D.
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T 818.241.9611 F 818.302.1699 www.PeterAshjian.com

Effective June 27, 2010, physicians in California must inform their patients that they are licensed by the Medical Board of California, and include the board's contact information.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

I understand Peter H. Ashjian M.D. is licensed and regulated by the Medical Board of California.

____________________________________ ________________
Patient/Guardian Signature Date