

Ashton A. Kaidi, M.D., F.A.C.S.
Plastic, Aesthetic and Reconstructive Surgery
Member, American Society of Plastic and Reconstructive Surgeons, Inc

PATIENT REGISTRATION

Date _____

Patient _____
FIRST MI LAST

SSN _____ Male/Female Birth date _____ Driver's License # _____

Home phone _____ Cell phone _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Circle the appropriate Minor Single Married Divorced Widowed

Patient's employer _____ Occupation _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you? _____

Name of person authorized to receive billing information? _____

Person to contact in case of emergency _____ Phone _____

PHOTOGRAPHS

I understand that any photographs taken to record the patient's condition remain Dr. Kaidi's property and may be used for professional purposes. No photograph showing both the face and an area of the body normally covered by a bathing suit will be used, nor will a name be released. I give permission for such use of these photographs.

Patient Signature

Parent or Guardian

Date

MEDICAL HISTORY

Patient Name: _____

Age: _____

Height: _____

Weight: _____

Number of Births: _____

Have you had any of the following?

Heart disease Yes No Date: _____

High blood pressure Yes No Date: _____

Angina Yes No Date: _____

A reaction or complication with local or general anesthetic? Yes No Date: _____

You or a family member ever had a bleeding disorder? If so, please specify Yes No Date: _____

Stomach or duodenal ulcer Yes No Date: _____

Pancreatitis Yes No Date: _____

Colitis Yes No Date: _____

Cancer Yes No Date: _____

Diabetes Yes No Date: _____

Kidney disease Yes No Date: _____

Human Immunodeficiency (AIDS) virus Yes No Date: _____

Thyroid disease Yes No Date: _____

Arthritis Yes No Date: _____

Convulsions or Seizures Yes No Date: _____

Nervous problems or psychiatric illness Yes No Date: _____

Depression Yes No Date: _____

Hepatitis _____ Yes No Date: _____

Jaundice Yes No Date: _____

Glaucoma Yes No Date: _____

“Dry Eyes” Yes No Date: _____

Anemia Yes No Date: _____

Rheumatic fever Yes No Date: _____

Mood disorder Yes No Date: _____

Please list all current medications (including birth control): _____

Please list the operations/ hospitalization you have had during your life

Do you smoke? Yes No if so, how much? 2 or less 2-10 more than 10 cigarettes per day

Do you drink alcohol? Yes No if so, how much? 1-2 drinks a wk 1-2 drinks a day more than 2 a day

Please list all known allergies: _____

Are you taking, or have you taken Cortisone or Prednisone within the past 2 years?

Within the past month, have you taken any medication containing ASA or Aspirin or other salicylates/salicylamides? (e.g. Alka Selzer, Anacin, Ascriptin, Bufferin, Darvon Compound, Equagesic, 222's, 282's, 292's, Florinal, Norgesic, Percodan, Robaxisal, Synalgos DC, Talwin Compound, some cold remedies and arthris tablets etc.):

Have you had any recent change in weight? _____

Do you have any shortness of breath, heartbeat irregularities or angina? _____

Do you have a chronic cough or asthma? _____

Have you ever thought about or attempted suicide? Yes No _____

MEDICAL INFORMATION

Patient Name: _____

Name of referring Doctor (if any) _____

Name of Primary Physician: _____

Address: _____

Phone: _____

Date of last chest X-ray _____ EKG: _____ Complete Physical: _____

Medical reports are routinely sent to primary and/or referring doctors. I give permission for release of medical information to Ashton A. Kaidi, M.D.

Patient Signature

Parent / Guardian

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birth date _____

Signature _____

Date _____

NOTICE TO CUSTOMERS

**Medical doctors are
Licensed and regulated by
The Medical Board of California**

(800) 633-2322

www.mbc.ca.gov