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

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?

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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 arthriris tablets etc.):

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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

ASHTON A. KAIDI, M.D., F.A.C.S.
1441 Avocado Avenue, Suite 601
Newport Beach CA 92660
Phone (949) 640-8576 Fax (949) 644-8763

OUT OF NETWORK CONSENT

I have been informed that Dr Kaidi is not a contracted/participating physician with my insurance carrier. I am also aware that I will be utilizing my Out-of-Network benefits and that any deductible, co-pay and balance will be my responsibility. Payment in full for each procedure will be collected at the time of my pre-op appointment.

I have been given the option to seek care from a contracted provider and/or contact my insurance company in order to receive healthcare services from a contracted provider for lower costs.

I have been informed that any costs incurred as a result of using my out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward my annual out-out-pocket maximum, in-network benefits or a deductible, if any, for in-network benefits.

I understand that Dr. Kaidi's office does not bill/submit any claims to my insurance company and that I am responsible for billing/submitting my own claims.

____________________________ ____________________________
Patient's Signature Date Signed

____________________________ ____________________________
Witness Date Signed

ASHTON A. KAIDI, M.D., F.A.C.S.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature: ________________________________ Date:____________________

Print Name: ______________________________ Telephone: ______________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ____

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NOTICE TO CONSUMERS

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

(800) 632-2322

www.mbc.ca.gov

Signature: _____________________________________ Date: ___________

Print Name: ___________________________________