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 or vape? Yes ☐ No ☐ if so, how much and how often? _____

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 chronically for the last 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 arthriris 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

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: _____

_____

_____

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: _____