PETER H. ASHJIAN, M.D.
PLASTIC & RECONSTRUCTIVE SURGERY
240 South Jackson Street Suite 109 Glendale, California 91205
Phone: (818) 241-9611 Fax: (818) 302-1699
www.peterashjian.com

(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 Number: ( ) Fax Number: ( )

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 ☐ Male ☐ Female	
Email address:	Driver License Number:	Social Security: - -	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:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Other				Phone #: ( ) -
Name of secondary insurance (if applicable):	Subscriber's Name:	Group#:	Policy Number#:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Other	Subscriber's S.S. #	DOB:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relation to patient:	Phone Number: ( ) -

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 Ashjian, M.D. or insurance company to release any information required to process any claims.

Patient/ Guardian signature : Date: / /

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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): _____

_____

_____

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Patient Name: _____
Last, First

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 (including 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? _____

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Patient Name: _____
Last, First

Smoking History: ____Never Smoked
____ Currently smoking(____ packs per day)
____ Quit smoking(____ years/months ago)
____ Nicotine patch

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, brusing, hair loss, itching lesions, acne, keloids): Yes ____ No ____

_____

Heent (migraines, hearing changes, nose bleeds, sore throat, hoarseness, sinus problems): Yes ____ No ____

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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 ____

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, dislocation, weakness): Yes ____ No ____

Neurologic (vertigo, headaches, syncope, seizure, 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, sucide ideation, hallucinations): Yes ____ No ____

Patient Name: _____
Last, First

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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

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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 claims 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 claims. 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 if contracted or the patient directly if there is no secondary insurance. Unfortunately, we are not a **MEDICAL** provider. We will then bill the patient directly for remaining balance.

Financial Responsibility:

I, the undersigned, do hereby assume full responsibility for the payment of the payment of the services rendered to the 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 (last, First) Patient's Agent or Representative

_____ _____

Signature Date

_____ _____

Witness Relationship to Patient

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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. There 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 group and to physicians at national meeting. 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 Educational Research (Please initial)

_____ I, undersigned, do hereby consent and agree that Dr. Peter Ashjian may use these photographs or videotapes 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 so hereby release to Dr. Peter Ashjian, its agents, and employees all rights to exhibit this work in print and electronic for, 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 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 may 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 the recording, including medical expenses due to any sickness or injury incurred as 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: _____

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Date: _____ Witness: _____

Acknowledgement of Receiving Notice of Privacy Practices

Glendale
240 South Jackson Street, Suite 109
Glendale California 91205

Sherman Oaks
5170 Sepulveda Blvd Suite 210
Sherman Oaks, CA 91403

I, _____

Received and understand the Notice of Privacy Practices.

_____ _____

Patients 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.

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Effective June 7, 2010, physicians in California must inform their patients that they are licensed by the Medial 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

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

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean the mother and the mother’s expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____

Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Print Patient Name: _____

By: _____ _____

Patient's or Patient Representative's Signature (Date)

Print Physicians Name: _____

By: _____ _____

Physician's or Authorized Representative's (Date)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

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PLASTIC & RECONSTRUCTIVE SURGERY

CALIFORNIA MEDICAL BOARD

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

Patient: _____

Signature: _____

Date: _____

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

OPERATIVE PLAN

Date: _____

Patient: _____

Diagnosis: _____

Surgical Plan: _____

_____

Schedule Surgery with: _____

Imaging: _____

Labs: _____

Medications: _____

_____

Other: _____