Bradley Ashpole M.D.
PLASTIC SURGERY

COMPREHENSIVE SURGICAL SPECIALISTS, LLC

PATIENT REGISTRATION

Please Print. All information will be confidential

Date: _____ Patient Name: _____
Last First Middle

Address _____ City _____ State _____ Zip _____

SS# _____ Birthdate _____ Age _____ Sex _____ Home Phone # (_____) _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Race: _____

Email Address _____ Cell phone # (_____) _____

Patient or parent/guardian's employer _____ Work Phone # (_____) _____

Address _____ City _____ State _____ Zip _____

Spouse or parent/guardian's name _____ Employer _____ Work Phone # (_____) _____

If patient is a student, name of school/college _____ City _____ State _____

Nearest Relative _____ (_____) _____
(Not Living with You) Name Relationship Telephone Number

Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency _____ Phone # (_____) _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone # (_____) _____

Email Address _____ Cell Pone # (_____) _____

Driver's License #: _____ Birthdate __ _____

Employer _____ Work Phone # (_____) _____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

1 Insurance Company _____ Insured Name _____

Insured Address _____ Insured Work Phone# (_____) _____

Employer Name _____ SS# _____ Insured Date of Birth _____ Relationship

#2 Insurance Company _____ Insured Name _____

Insured Address _____ Insured Work Phone# (_____) _____

Employer Name _____ SS# _____ Insured Date of Birth _____ Relationship: _____

I request all payments be made to *Comprehensive Surgical Specialists, LLC* on my behalf for any services furnished to me by *Comprehensive Surgical Specialists, LLC. I* authorize the release of any medical or non medical information to appropriate agencies for the processing of benefits. I understand should I have insurance; I am ultimately responsible for all charges incurred at *Comprehensive Surgical Specialists, LLC. I* further understand, should I default in payment that I am responsible for any and all collection costs and/or attorney fees incurred. According to HIPPA guidelines, I acknowledge that I have had available and/or received the NOTICE OF PRIVACY PRACTICES from *Comprehensive Surgical Specialists, LLC.*

X_____

Signature of patient (or parent/guardian if minor) **Date**

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WELCOME TO OUR PRACTICE

Your health is of extreme importance to us. The more we know about you, the better we can assist you.
Please complete the information on the following pages to the best of your ability.

Date: _____ **Patient Name:** _____ **Date of Birth** _____ **Age:** _____

Chief Complaint: _____

History of Present Illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal versus abnormal color, activity, etc.)

Severity: _____
(How severe is the pain/problem on a scale of 1-5 (5 being the most severe)

Duration: _____
(How long have you had this pain problem or when did it start?)

Timing: _____
(Does this pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?}

Associated Signs/Symptoms _____
(What other associated problems have you been having?)

Modifying Factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Patient Medical History:

Have you ever had the following (check "yes" or "no", leave blank if uncertain):

AIDS or HIV positive	☐ No	☐ Yes	**Diabetes**	☐ No	☐ Yes	**Psychiatric Evaluation**	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	**Ear/Eye Problems**	☐ No	☐ Yes	**Rheumatic Fever**	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	**Glaucoma**	☐ No	☐ Yes	**Seizures**	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	**Heart Disease**	☐ No	☐ Yes	**Shortness of Breath**	☐ No	☐ Yes
Back Problems	☐ No	☐ Yes	**Heart Murmur**	☐ No	☐ Yes	**Skin Cancer**	☐ No	☐ Yes
Blood Clots in Legs	☐ No	☐ Yes	**Heart Palpitations**	☐ No	☐ Yes	**Stroke**	☐ No	☐ Yes
Blood Disorders	☐ No	☐ Yes	**Hepatitis**	☐ No	☐ Yes	**Thyroid Disease**	☐ No	☐ Yes
Bleeding/Bruising	☐ No	☐ Yes	**High or Low Blood Pressure**	☐ No	☐ Yes	**Tuberculosis**	☐ No	☐ Yes
Breathing Problems	☐ No	☐ Yes	**Hives or Eczema**	☐ No	☐ Yes	**Transfusion**	☐ No	☐ Yes
Bronchitis	☐ No	☐ Yes	**Irregular Heart Beat**	☐ No	☐ Yes	**Any other Disease**	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	**Kidney Disease**	☐ No	☐ Yes	**(Please List):** _____		
Chest Pains	☐ No	☐ Yes	**Migraine Headaches**	☐ No	☐ Yes	_____		
Chronic Cough	☐ No	☐ Yes	**Mitral Valve Prolapse**	☐ No	☐ Yes	_____		
Chickenpox	☐ No	☐ Yes	**Nervous Breakdowns/ Emotional Disorders**	☐ No	☐ Yes	_____		
Cold Sores	☐ No	☐ Yes	**Nose/Throat Problems**	☐ No	☐ Yes	_____		
Colitis	☐ No	☐ Yes	**Pneumonia**	☐ No	☐ Yes	_____		

Have you ever had a mammogram? ☐ **No** ☐ **Yes** **If, when was your last one?** _____

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Date: _____ **Patient Name:** _____ **Date of Birth** _____

Patient Medical History

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital	City	State

Medications:

Are you allergic to or have you ever had a reaction to any medication or drug ; local anesthetic.; or general anesthetic? If so, please list medication and type of reaction:

_____

_____

Are you currently taking any medication including aspirin, birth control pills, herbs, vitamins ect? ☐ **No** ☐ **Yes**

If yes, please list: _____

_____

_____

Patient Social History

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Use of Alcohol ☐ **Never** ☐ **Rarely** ☐ **Moderate** ☐ **Daily**

Use of Tobacco: ☐ **Never** ☐ **Rarely** ☐ **Previously but quit** _____ ☐ **Current packs/day :**_____

Use of Drugs: ☐ **Never** ☐ **Type/ frequency :**_____

Excessive exposure to sun ☐ **No** ☐ **Yes** ***Exposure to Radiation*** ☐ **No** ☐ **Yes**

Family Medical History

	Age	Disease	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Do you or any member of your family have a problem with excessive scarring or keloid formation after being cut? ☐ **No** ☐ **Yes**

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BRADLEY L. ASHPOLE, M. D.

Comprehensive Surgical Specialists, LLC

PERMISSION TO CONTACT OR LEAVE MESSAGE

With the enactment of the Health Insurance Portability and Accountability Act of 1996, Comprehensive Surgical Specialists, LLC recognizes that a patient has the right to have his or her health information kept private and secure.

As part of Comprehensive Surgical Specialists, LLC Quality Assurance Plan, we may find it necessary, at times, to call you or leave a message for you to call us

_____I grant permission for Comprehensive Surgical Specialists, LLC to contact me regarding information that they might need for my care. They may leave a message with a person at my home or leave a message on a recorder.

_____Yes, you may call, but speak only with me. Do not leave a message.

_____ I prefer that you contact me only at this number:

Home: _____

Work: _____

Other: _____

_____ _____
Patient Name (Printed) **Date**

_____ _____
Patient (Signature) **Date**

_____ _____
Witness (Comprehensive Surgical Specialists Staff) **Date**

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COMPREHENSIVE SURGICAL SPECLALISTS, LLC

FINANCIAL POLICY

We are committed to providing you, our patient with the best possible care at reasonable fees. However, we must explain that our relationship is with you and not with your insurance company.

It is important that you read and understand the following:

1. **Your insurance contract is between you and your insurance company. Wean not a party to that contract It is important that you understand your insurance coverage.**

2. **Our fees fall within the reasonable and customary range allowed by most insurance companies.**

3. **You are responsible for amounts not paid by your insurance company which includes insurance deductibles, co-payments, coinsurance, and any services not covered by your insurance plan.**

4. **Not all services are considered as medically necessary covered services. It is important that you know what services are covered and not covered by your policy.**

5. **If your insurance plan requires that you have a referral to see as, it is YOUR responsibility to provide our office with that referral to each visit/treatment. We will not be able to see you if the referral is not in place prior to your appointment.**

INITIAL OFFICE VISITS: We obtain insurance information from you upon scheduling your first visit with our office. We will be calling your insurance company to verify *your* benefits. If your deductible has not been met or if your plan does not pay for office visits, you will be responsible for paying for the office visit at the time services are rendered. We will file a claim with your insurance company to help meet your deductible. Our payment options are: Visa, MasterCard, Discover, Care Credit, personal checks and cash. There is a $25.00 fee for all returned checks.

We may or may not be a preferred provider for your insurance plan. Please check with the front desk if you have a question regarding your insurance plan and our provider status.

If surgery is recommended and you do not have insurance, it is our policy to have full payment in advance for our services. Our payment options are: Visa, MasterCard, Discover, American Express, Cashier's check or Money Order and patient financing through Care Credit.

***NOTE:* The number of no charge follow-up care days included in your surgical fee varies depending on the procedure performed. The follow-up care days range from 10 to 90. We will be glad to provide you with that information should a surgical procedure be scheduled.**

Attempts will be made to help you understand our financial policy and your obligations. If you have any questions regarding our financial policy please ask prior to signing below.

My signature below acknowledges that I have read and understand the above financial policy for *Comprehensive Surgical Specialists, LLC,* that I authorize my insurance company to pay benefits to *Comprehensive Surgical Specialists, LLC* (Bradley R. Ashpole, M.D.), and that I understand I am financially responsible for services not covered or paid by my insurance company according to my level of benefits.

_____ _____

RESPONSIBLE PARTY SIGNATURE **DATE**

Bradley Ashpole M.D.
PLASTIC SURGERY

COMPREHENSIVE SURGICAL SPECIALISTS, LLC
CONSENT/RELEASE FORM

Patient: _____ Date: _____

In connection with the medical services that I am receiving from my physician, Dr. Bradley Ashpole, I consent that photographs may be taken of me or parts of my body, under the following checked conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him/her.

2. The photographs shall be taken by my physician or by a photographer approved by my physician.

3. The photographs shall be used for medical records, and if in the judgment of my physician, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose that may be deemed proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name.

4. The aforementioned photographs may be modified or retouched in any way that my physician may consider desirable.

_____ _____
Patient Signature **Date**

_____ _____
Witness Signature **Date**

"I hereby grant permission for the use of any of my medical records, including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc."

_____ _____
Patient Signature **Date**

_____ _____
Witness Signature **Date**

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Patient Signature: _____

Witness Signature: _____

Date: _____

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How Did You Learn About

Dr. Ashpole?

Please check all statements that apply:

☐ **My friend, _____, told me about Dr. Ashpole?**

☐ **My doctor, _____, referred me to this office.**

☐ **Magazine Ad**

☐ **Newspaper Ad**

☐ **Your location is convenient to my home or office.**

☐ **I visited your web site.**

☐ **Used search engine: Google, MSN, Yahoo Other:_____**

Keyword(s) searched: _____

☐ **Referred by another website:_____**

☐ **Other: _____**

Thank you for taking the time to complete this information