Cosmetic Plastic Surgery
& Laser Center of Maryland

Salman Ashruf, M.D.
7550 Teague Road, Suite 105
Hanover, MD 21076
Tel: (410) 590-4313 Fax: (410) 690-7743
E-mail: doc@drashruf.com
www.drashruf.com

Today's Date:

PATIENT INFORMATION

Last name:	First Name:	Middle:

Marital Status: (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Date of Birth:	Age:	Sex: ☐ Male ☐ Female

Address:	Height:	Weight:

City:	State:	Zip:

Social Security Number:	Home Phone:	Cell Phone:

E-mail Address:

Occupation:	Employer:	Employer Address:	Employer Phone:

How did you hear about us?

Other family members seen here:

MEDICAL INFORMATION

(Please give your insurance card to the receptionist.)

Reason for visit:

Pharmacy:	Address:	Pharmacy Phone:

Physician Requesting Consultation:	Requesting Physician's Address:	Requesting Physician's Phone:

Primary Care Physician (PCP):	Send Report: ☐ Yes ☐ No

PCP's Address:	PCP's Phone:	PCP's Fax:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Contact Number:

HEALTH HISTORY

Do you smoke or chew tobacco? ☐ Yes ☐ No How much? _____	Do you drink alcohol? ☐ Yes ☐ No How much? _____	Do you exercise? ☐ Yes ☐ No

HEALTH HISTORY (CONTINUED)

Please list all medicine you are currently taking: Prescription and over-the-counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include any medications taken as needed (example: inhaler, EpiPen).

Medication Name	Dose (How much?)	Frequency (How often?)

Please list all allergies:

_____
_____
_____
_____
_____
_____

Are you allergic to Latex?

☐ Yes
☐ No

Are you currently experiencing any of the following symptoms?

☐ None	☐ Diarrhea	☐ Rectal Bleeding
☐ Bleeding	☐ Dizziness	☐ Ringing in the Ears
☐ Blind Spells	☐ Dry Eyes	☐ Severe Headaches
☐ Breast Pain	☐ Fainting Spells	☐ Severe Indigestion
☐ Chest Pain	☐ Fever	☐ Shortness of Breath
☐ Chronic Cough	☐ Jaundice	☐ Spitting up Blood

Please check if you have or ever had any of the following:

☐ Anemia	☐ Dentures	☐ HIV	☐ Paralysis
☐ Angina	☐ Depression	☐ Hypertension	☐ Pneumonia
☐ Anxiety Disorder	☐ Diabetes	☐ Implants/Artificial	☐ Prolonged Bleeding
☐ Arthritis	☐ Emotional Disorder	☐ Irregular Heartbeat	☐ Recent Cold
☐ Asthma	☐ Emphysema	☐ Jaundice	☐ Shortness of Breath
☐ Back Pain	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Sickle Cell Anemia
☐ Bladder Trouble	☐ Fainting/Dizziness	☐ Kidney Stones	☐ Sleep Apnea
☐ Blood Disease	☐ GI Disorder	☐ Liver Disease	☐ Stroke
☐ Bronchitis	☐ Hay Fever	☐ Loose Teeth	☐ Swollen Ankle
☐ Cancer/Tumor	☐ Hearing Aid	☐ Lung Disease	☐ Thyroid Disease
☐ Chronic Cough	☐ Heart Attack	☐ Lyme Disease	☐ Tuberculosis
☐ Cirrhosis	☐ Heart Disease	☐ Neurological Disorder	☐ Ulcer
☐ Colon Disease	☐ Heart Failure	☐ Osteoporosis	☐ Other:
☐ COPD	☐ Hepatitis	☐ Painful Joints	
☐ Coronary Artery Disease	☐ Hiatal Hernia	☐ Pacemaker	

Family History – List any medical conditions of immediate family:

Have you ever had any serious illnesses, past surgeries or hospitalizations? ☐ **Yes** ☐ **No**

If yes, please describe and list dates:

The above information is true to the best of my knowledge. If applicable, I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance, co-pay and/or deductible. I also authorize Salman Ashruf, MD, or the insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

Salman Ashruf, M.D., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been made aware of a Notice of Privacy Practices for Salman Ashruf, M.D., P.A. If you have any questions, please contact the Privacy Officer whose name and contact information is listed below.

_____

Please Print Name of Patient or Personal Representative

_____

Patient or Personal Representative Signature

_____

Date

_____

Personal Representative's Relationship or Authority

Privacy Officer:

Salman Ashruf, M.D., P.A.
7550 Teague Road, Suite 105
Hanover, MD 21076
Tel: (410) 590-4313
Fax: (410) 690-7743

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please specify): _____

Cosmetic Plastic Surgery
& Laser Center of Maryland

Salman Ashruf, M.D.
7550 Teague Road, Suite 105 Hanover, MD 21076
Tel: (410) 590-4313 Fax: (410) 690-7743

E-mail: doc@drashruf.com

www.drashruf.com

MY CONSULTATION GOALS

Name: _____ Date: _____

ID Number: _____ Date of Birth: _____

How did you hear about us?

1) Please list the top 3 problems on your "Hit List" that you would like to see improved after surgery (you may list fewer):

FACE	BODY
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____

2) Please list the next 3 concerns (if applicable) you would want to address during your consultation:

1. _____
2. _____
3. _____

3) What adjective(s) best describe your face or body now?

For example: **FACE:** *rested, youthful, fresh* **OR** *tired, angry, sad, droopy, wrinkly, etc.*

BODY: *tight, firm, balanced* **OR** *droopy, saggy, loose, disproportionate, etc.*

FACE: _____

BODY: _____

Approximate Measurements in Inches:

WAIST_____**HIPS**_____

4) GOALS ; What is it you need to see when you look in the mirror in order to be happy after surgery?

_____

_____

_____

5) If you have surgery, how much downtime and/or time off work can you devote to your recovery?

_____ week(s)

6) What non-surgical skin concerns bother you?

☐ Wrinkles ☐ Pores ☐ Texture ☐ Brown Pigmentation

☐ Dark Circles ☐ Cellulite ☐ Red Vessels ☐ Other: _____

8) What non-surgical treatments have you had?

☐ Botox ☐ Filler (Restylane/Juvederm ect) ☐ IPL/Laser Fotofacial

☐ Laser Hair Removal ☐ Cellulite Treatments ☐ Thermage/ Laser Tightening

☐ Fraxel/Laser Resurfacing ☐ Other: _____

9) What is your treatment budget?

☐ Up to $500 ☐ $500 - $1500 ☐ $1500-$2500 ☐ $2500-$5000 ☐ $5000-$7500 ☐ $7500 and Up

_____ _____

Patient's Name (Please print) **Date**

_____ _____

Patient's Signature **MD Signature**