Cosmetic Plastic Surgery
& Laser Center of Maryland

Prior to your scheduled appointment, please download and fill out these patient forms. Please email your completed forms to info@drashruf.com.
Note: Forms must be completed on a PC or desktop computer.

Please feel free to reach out if you have any questions before your appointment.

Having trouble editing? Please use this Adobe software:
www.get.adobe.com/reader/

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?	Do you drink alcohol?	Do you exercise?
☐ Yes ☐ No How much? ________	☐ Yes ☐ No How much? ________	☐ 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
- ☐ Bleeding
- ☐ Blind Spells
- ☐ Breast Pain
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Dry Eyes
- ☐ Fainting Spells
- ☐ Fever
- ☐ Jaundice
- ☐ Rectal Bleeding
- ☐ Ringing in the Ears
- ☐ Severe Headaches
- ☐ Severe Indigestion
- ☐ Shortness of Breath
- ☐ Spitting up Blood

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

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

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): ________________________________

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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**