

**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  
Email Address \_\_\_\_\_ Cell phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Patient or Guardian Name: \_\_\_\_\_ Work Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Address (If different from Patient) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
If patient is a student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Relationship \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of person responsible for this account (If not patient) \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address (if different from Patient) \_\_\_\_\_ Home Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Birthdate \_\_\_\_\_ Cell Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

**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 *Bradley Ashpole, M.D.* on my behalf for any services furnished to me by *Bradley Ashpole, M.D.* . 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 with *Bradley Ashpole, M.D.* 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 *Bradley Ashpole, M.D.* .**

X \_\_\_\_\_  
Signature of patient (or parent/guardian if minor ) Date

## WELCOME

**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 Condition:

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 makes the problem better or worse? : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Patient Medical History:

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

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

Have you ever had a mammogram?  No  Yes    If, when was your last one? \_\_\_\_\_

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 Sun Exposure  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

## FINANCIAL POLICY

Bradley Ashpole, M.D. &  
Narendra K. Garg, M.D., P.C.

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. We are 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 us, 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 Bradley Ashpole, M.D. and that I authorize my insurance company to pay benefits to *Narendra K Garg, M.D., P.C.* (Bradley L. 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.

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RESPONSIBLE PARTY SIGNATURE

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DATE

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RESPONSIBLE PARTY SIGNATURE

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DATE

**BRADLEY L. ASHPOLE, M. D.**

**PERMISSION TO CONTACT OR LEAVE MESSAGE**

With the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Bradley L. Ashpole, M.D. 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 or you may speak with

\_\_\_\_\_  
Name of Authorized Person

\_\_\_\_\_  
Relationship

\_\_\_\_\_ I prefer that you contact me only at this number:

\_\_\_\_\_

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Comprehensive Surgical Specialists Staff)

\_\_\_\_\_  
Date



## PHOTOGRAPH 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

## ***How did you learn about our practice?***

**Please check all statements that apply:**

My friend, \_\_\_\_\_, told me about Dr. Ashpole

My doctor, \_\_\_\_\_, referred me to this office.

Television 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***