**ARTISTIC PLASTIC SURGERY CENTER**
**Dr. Khash Dehghan, MD. PhD, FACS**
**Certified American Board of Plastic Surgery**
**American Society For Aesthetic Plastic Surgery**

Date ____________________
Referred By: ____________________
Dr. Phone No. ____________________
Account No. ____________________

Name: ____________________ Date of Birth: __________ Age: __________

Social Security No. ____________________ Mr. ____ Ms. _____ Mrs. _____ Miss _____ Other _____

Home Phone: ____________________ Cell Phone: ____________________

Address: ________________________________________

City: ____________________ State: __________ Zip: __________

Employer: ____________________ Work Phone: ____________________

Address: ____________________ State: __________ Zip: __________

Emergency Contact: ____________________ Phone: __________ Relation: __________

## PLEASE FILL IN THE BELOW PORTIONS IF APPLICABLE

Spouse's Name: ____________________ Date of Birth: __________ SSN: __________

Employer: ____________________ Work Phone: ____________________

Father's Name: ____________________ Date of Birth: __________ SSN: __________

Employer: ____________________ Work Phone: ____________________

Mother's Name: ____________________ Date of Birth: __________ SSN: __________

Employer: ____________________ Work Phone: ____________________

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative or other individual to the extent necessary to help with your health care or with payment for your health care. List below individuals to whom we MAY NOT release personal health information:

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

## INSURANCE INFORMATION

| Primary | | Secondary | |
|---|---|---|---|
| Plan Name: | | Plan Name: | |
| Subscriber: | | Subscriber: | |
| Address: | | Address: | |
| City/State/Zip: | | City/State/Zip: | |
| ID: | Group: | ID: | Group: |
| Co-Pay: $ | Phone: | Co-Pay: $ | Phone: |

On the job injury? Yes No Claim No. __________ Date of injury:

How did the accident occur? ____________________ Where? __________