Chernoff Cosmetic Surgery

PATIENT REGISTRATION

Patient Name_____ Birth Date_____ Age_____
Last First Middle Initial

Current
Address_____
Street City State Zip

Cell Phone _____ Other Phone _____
Circle Preferred

E-mail _____

By providing my email and cell phone, I agree to receive communication from Dr. Chernoff's office by email and text messages about upcoming appointments, newsletters, offers and events.

Patient Employer _____Employer Phone: _____

If Patient is a child _____
Parent or Guardian Name *Address (if different than above)*

ADDITIONAL INFORMATION

Spouse or Partner Name: _____Phone: _____

Referring M.D: _____Phone: _____

Emergency Contact: _____Phone:_____

How did you hear about us? Please check the space below of which source referred you.

Family or Friend _____

_____
Name of person who referred you

Medical Office _____

_____
Doctor or office who referred you

Google Search _____

Facebook _____

Other Social Media _____

Press Democrat Printed Paper _____

Press Democrat Online _____

Salon / Spa _____

Name: _____

Chamber of Commerce _____

LaserVue Eye Center _____

Other: _____

To ensure patient financial confidentiality, please discuss *all* financial arrangements with the patient coordinator. I understand that I am personally responsible for all charges. I understand that the charges I am responsible for are to be paid in full at the time of service. Should collection proceedings become necessary, I understand that I will be responsible for reasonable attorney fees, court cost and all collection cost.

Signature: _____ Date:_____

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PATIENT MEDICAL HISTORY

Please answer and complete each section and question.

NAME:_____ **DATE:** _____

Reason for today's visit:

_____

_____

_____

_____

DOB:_____-_____-_____ **Age:**_____ **Ht:**_____**ft**____**in** **Wt:**_____**lbs**

Allergies to Medication: (If none, write N/A)

_____

_____

Married _____ Single_____ Divorced _____

Widowed ____ Partner _____ How many children? ____

Personal or Family History:

Cancer (Breast/Skin etc.):____**Yes**____**No**
Keloids or Abnormal Scarring: _____**Yes**_____**No**
Bleeding or Genetic Disease: _____**Yes**_____**No**
History of adverse reactions with anesthesia?_____**Yes**____**No**
Do you have a history of Drug Abuse (prescription or recreational drugs)?___**Yes**___**No**

Medications:_____

_____

_____

Family Physician:_____ **Phone Number:** _____

Previous Surgeries:_____

_____

Previous cosmetic procedures or treatments? Was result expected? _____

_____

Past Medical History:

Description	**Yes**	**No**	**Description**	**Yes**	**No**
Dentures	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Metal Implants	[ ]	[ ]	Neurological Disease	[ ]	[ ]
Contact Lenses	[ ]	[ ]	Heart Disease	[ ]	[ ]
Pacemaker/Defibrillator	[ ]	[ ]	Liver Disease	[ ]	[ ]
Seizures	[ ]	[ ]	Lung Disease	[ ]	[ ]
Diabetes	[ ]	[ ]	Kidney Disease	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Thyroid Disease	[ ]	[ ]
Currently Pregnant	[ ]	[ ]	Intestinal Disorder	[ ]	[ ]
Currently Breast Feeding	[ ]	[ ]	Hypo/Hyperpigmentation	[ ]	[ ]
Smoker	[ ]	[ ]	Antibiotics within 14 days	[ ]	[ ]
Packs per day? _____			Accutane in last 6 months	[ ]	[ ]
Other: _____					

All of the above information is true and correct. _____

PATIENT SIGNATURE

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FINANCIAL POLICY

OFFICE PROCEDURES: Must be paid in full at time of treatment.

SURGICAL PROCEDURES: Must be paid in full before any procedure is performed.

POLICY ON PURCHASES: All services purchased are to be paid in full at the time of purchase. Services are non-refundable, non-transferable and expire one year from date of purchase.

PRODUCT RETURNS: All opened and unopened products returned within 10 days will be credited to your account and may be used toward products or services. No returns or exchanges are accepted after 10 days.

POLICY ON PACKAGE PURCHASES: All packages purchased are to be paid in full at the time of purchase. Packages are non-refundable. Packages are non-transferable.

RETURNED CHECKS: There will be a charge in the amount of $35.00 for any returned check. This policy is strictly enforced, and future treatments MAY be withheld until NSF checks have cleared the bank. Alternate payment methods may also be required.

CANCELLATION POLICY: We kindly ask that you give 2 business days (M-F) notice if canceling or changing an appointment. In the event of less than 2 business days notice or a "no show", there will be a charge of $85.00. Repeat cancellations without 48 hours notice will be required to provide us with a credit card to hold their appointment time.

By signing below, I certify that I have read and understand the above stated information. I understand, once again, that I am responsible for full payment at time of service. I will also be responsible and liable for all collection of fees incurred while enforcing collection of said amount.

_____ _____

Signed (Patient or Responsible Party) Date

Chernoff Cosmetic Surgery

CONSENT TO USE PHOTOS

I give my consent that a photo (of any part of me) can be used, shown, and published in:

Check all that apply:

- ☐ Office Educational Materials
- ☐ Seminars or Educational Presentations by Dr. Chernoff
- ☐ Dr. Chernoff's Website Before & After Gallery
- ☐ Video or Commercials (TV)

- ☐ **All The Above**

- ☐ I prefer to only have my photos used for chart purposes only

_____ _____

Name Printed Date

_____

Signature

If signed above, I represent that I am over 21 years of age.

If I have granted permission to Chernoff Cosmetic Surgeons to use my photo or video, I agree there is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. I waive any right to royalties or compensation for the use of my image or recording. By granting permission to use my photo or video, I acknowledge that I have completely read and fully understand the above release. I release any and all claims against Chernoff Cosmetic Surgery for using the material. If I wish to change my photo consent, I will send an email to office@drchernoff.com with my request.

IF UNDER 21 YEARS OF AGE -- Consent of Parent or Guardian

I,_____, am the parent/guardian of _____

I give my consent to the above photo consent.

_____ _____

Parent Name Date

_____

Parent Signature

Chernoff Cosmetic Surgery

ACKNOWLEDGMENT OF HIPAA PRIVACY PRACTICES

On occasion, a family member, friend, or caregiver may contact Chernoff Cosmetic Surgeons to inquire about your medical information. Please list those individuals to whom the information may be disclosed.

NAME(S) RELATIONSHIP

_____

_____

I acknowledge that I have read or received a copy of Chernoff Cosmetic Surgeons Notice of Privacy Practices.

Signature: _____

Printed Name: _____

Date: _____

If you are completing our new patient paperwork prior to coming to the office, you will be provided a copy of our privacy practices when you come to the office and you can sign this form at that time.