Chernoff Cosmetic Surgery
PATIENT REGISTRATION FORM

Patient Name_____Birth Date_____Age_____
Last First Middle Initial

Current Address_____
Street City State Zip

Cell Phone _____ Other Phone _____
Preferred 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 under 18 years old _____
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 /Instagram_____

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:_____

Chernoff Cosmetic Surgery - *MEDICAL HISTORY*

NAME: _____ **DATE**: _____

Date of Birth_____ Age_____ Ht _____ft _____in Wt _____lbs

Reason for today's visit_____

Primary doctor & phone number_____

Preferred pharmacy location & phone number_____

ALLERGIES: ____Y ____N If yes, please list below and the type of reaction

Medication_____

Environmental, chemical, food _____

MEDICATIONS (prescription or non-prescription): ____Y ____N If yes, please list below and the dosage

_____

_____

Supplements, homeopathic products, vitamins _____

_____

Skin care products used _____

_____

Alcohol ____Y ____N If Yes, please circle type of alcohol: wine/beer/liquor

How much_____How often_____

Smoking ____Y ____N If Yes, please circle type of smoking: vape/nicotine/cannabis

How much_____How often_____

History of/or current drug use ____Y ____N If yes, please specify_____

SURGICAL PROCEDURES AND COSMETIC TREATMENTS:

All previous surgeries and year_____

_____

Are you happy with your surgery results ____Y ____N If No, why not_____

Previous cosmetic treatments and last time treated_____

_____

Are you happy with your treatment results ____Y ____N If No, why not_____

FAMILY MEDICAL HISTORY:

Cancer	___Y ___N	Adverse reactions with anesthesia	___Y ___N
Autoimmune diseases	___Y ___N	Thick or abnormal scarring or keloids	____Y ___N
Bleeding or genetic disease	____Y ____N	Diabetes	____Y ____N
Heart Attack	___Y ___N	High blood pressure	_Y _N Stroke
Y ____N	Other_____	____Y ____N	

I understand that pregnancy is contraindicated with all surgical procedures and office treatments.
_____*Patient initials*

PERSONAL MEDICAL HISTORY:

Currently pregnant ____ Y ____ N

Breast feeding ____ Y ____ N

Eye conditions ____ Y ____ N

Contact lenses ____ Y ____ N

Incomplete opening/closing eyes ____ Y ____ N

Teeth implants ____ Y ____ N

Dentures ____ Y ____ N

Surgical implants/devices ____ Y ____ N

Pacemaker ____ Y ____ N

Adverse reaction anesthesia ____ Y ____ N

Bodily Injury ____ Y ____ N

Chronic pain ____ Y ____ N

Diabetes ____ Y ____ N

Cancer ____ Y ____ N

Skin cancer ____ Y ____ N

Abnormal scarring/keloids ____ Y ____ N

Open wounds ____ Y ____ N

Current infection ____ Y ____ N

Antibiotics in last 14 days ____ Y ____ N

Sun sensitivity ____ Y ____ N

Hypo/hyperpigmentation ____ Y ____ N

Active acne or scarring ____ Y ____ N

First day of last menstrual period _____

Number of pregnancies_____ Number of births_____

Type of contraception_____

Thyroid conditions ____Y ____N

Heart conditions ____Y ____N

Lung conditions ____Y ____N

Autoimmune diseases ____Y ____N

Intestinal conditions ____Y ____N

Liver conditions ____Y ____N

Kidney conditions ____Y ____N

Neurological conditions ____Y ____N

Facial or neck weakness ____Y ____N

Difficulty swallowing ____Y ____N

Seizures ____Y ____N

Sleep apnea ____Y ____N

High blood pressure ____Y ____N

Bleeding/clot disorder ____Y ____N

Genetic disease ____Y ____N

Arthritis ____Y ____N

Cold sores/fever blisters ____Y ____N

Rosacea ____Y ____N

Skin Conditions ____Y ____N

Accutane in last 6 months ____ ____ Other_____Y ____N
Y N

If Yes to any of the above, please specify_____

_____

All of the above is true, complete and correct. _____
Signature

PHOTOS FOR MEDICAL CHART:

Chernoff Cosmetic Surgery requires that photos are taken before and after treatment as well as to document your response to treatment(s). By receiving care at Chernoff Cosmetic Surgery, I give my consent for my photos to be taken and used for medical reasons.

Chernoff Cosmetic Surgery

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.

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 48 hours notice if canceling or changing an appointment. In the event of less than 48 hours 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

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

_____

_____

Signature: _____

Printed Name: _____

Date: _____

View our privacy policy at: ChernoffCosmeticSurgery.com – Patient Forms

LINK TO VIEW