CHERNOFF
COSMETIC SURGERY

# PATIENT REGISTRATION FORM

Patient Name________________________________________________ Preferred Name____________________
Birth Date ____________ Phone ________________________ Email _______________________________________

Current Address_________________________________ ___________________ ________ ___________
*Street* *City* *State* *Zip*

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

IF PATIENT IS CHILD: _______________________________________________________________________
*Parent/guardian name & address (if address is different than above)*

## ADDITIONAL INFORMATION

Spouse Name _______________________________________ Spouse Phone Number_________________________
Your Employer __________________________________Spouse Employer __________________________________

**PERSON TO CONTACT IN CASE OF AN EMERGENCY:**

NAME: _________________________________________ RELATIONSHIP: ______________________
PHONE: _______________

Address of Relative _______________________________________________________________________
Street City State Zip

## How did you hear about us?

**SALONS/SPAS**
___ Tonya Carpenter
___ Jata Hair Salon
___Nicole Bryan Salon
___Conrad/ Evan Todd
___Sage Salon
___The Skin Spot Care/Julie McClain

**MEDICAL**
___Dr. Chernoff
___Dr. Spurgin
___Geist Family Practice
___Indiana Eye Clinic

___Dr. L Rader
Physician:
_____________________

**OTHER**
___Chernoff Cosmetic Surgery Website
___Google Search
___Real Self
___Social Media
___Nicole Pence Blog
___Yellow Pages
___Silvia Love

___Indy Metro Woman
___Sophisticated Living Magazine
___Columbia Club
___TV/Radio Station
___Newspaper
___Seminar
___LA Fitness
___Life Time Fitness
___Massage Envy
___Lilly Employee
___Chernoff Bazaar

**All packages are to be paid in full at the time of purchase. All Services are NON-REFUNDABLE.**
**Pre-Payment for Laser, Fillers, Botox and Surgical deposits are NON-REFUNDABLE.**
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___________________
______________________________________________________________
______________________________________________________________

**Chernoff Cosmetic Surgery**

*MEDICAL HISTORY*

**FAMILY MEDICAL HISTORY:**

Cancer ____Y ____ N
Autoimmune diseases ____Y ____ N
Bleeding or genetic disease ____Y ____ N
Heart Attack ____Y ____ N
Stroke ____Y ____ N

Adverse reactions with anesthesia ____Y ____ N
Thick or abnormal scarring or keloids ____Y ____ N
Diabetes ____Y ____ N
High blood pressure ____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
Accutane in last 6 months ____Y ____ N
HIV ____Y ____N
Hepatitis ____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
Other_________________ ____Y ____ N

If Yes to any of the above, please specify________________________________________________________________

______________________________________________________________________________

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

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**NO SHOW & CANCELLATION POLICY**
We are often on a waiting list for appointments. In order to allow patients on our waiting list appointments, we kindly ask that you give **2 business days** (M-F) if canceling or changing an appointment. In the event of less than 2 business days or a "no show," there will be a charge of $85.00 posted to your account.

**COSMETIC PROCEDURES**: All cosmetic procedures must be paid in full at the time of service. Surgical procedures must be paid in full before any procedure is performed.

**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.

**SKIN CARE PRODUCT PURCHASES:** All returned unopened product boxes will be credited to your account and may be used toward any services if returned within 30 days of purchase. All opened product sales are final and cannot be refunded.

**RETURNED CHECKS**: There will be a charge in the amount of $30.00 for any returned check. This policy is strictly enforced, and future treatments MAY be withheld until NSF checks have cleared the bank.

**FINANCIAL ARRANGEMENTS**: Our commitment of excellence through our various services is extended to you with regard to the payment of our services. In order to achieve this goal, definite payment arrangements must be established by your second visit. All charges quoted pertain only to Dr. Chernoff's charges additional charges will also be charged to you from outside sources with all surgery cases.

**ALL REFUNDS WILL BE PROCESSED WITHIN 120 DAYS OF APPROVAL.**

**WAITING ROOM:** We strive to provide the best treatment in a relaxing environment, so please make child care arrangements in advance and mute all cell phones.

**PRIVATE INSURANCE COVERAGE**: You are responsible for the full amount of our charges. You may keep your receipt and file directly with your insurance.

**NO INSURANCE**: Payment in full is expected at each visit. Should you require prolonged treatment; a monthly payment arrangement can be established. At the conclusion of your treatment, all services are to be paid in full within 60 days.

**WORKER'S COMPENSATION**: A confirmation, by phone or other means, is required to acknowledge the services as Worker's Compensation. If by letter, that letter should include a claim mailing address and the contact person at your place of employment.

**ACCIDENT CASES**: Accident cases are considered self-pay and we do not become involved in litigation of the settlement of these cases except where required by Federal law (Medicare/Medicaid). You will be given a receipt for any payment made to pursue your claim in these situations.

**NO CHALLENGE POLICY:** Services that are performed and are paid with a credit card, or financing third party are not eligible for payment challenges after services are provided. I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this non-credit card challenge agreement is irrevocable.

By signing below, I certify that I have read and understand the above stated information. I understand, once again, that I am responsible for any amount not covered by insurance. I will also be responsible and liable for all collection of attorney fees incurred while enforcing collection of said amount.

Printed Name ____________________________________________________

Signed (Patient or responsible party)______________________________________________Date_________________

**ACKNOWLEDGMENT OF HIPAA PRIVACY PRACTICES**

ON OCCASION A FAMILY MEMBER, FRIEND OR CAREGIVER MAY CONTACT CHERNOFF AND ASSOCIATES TO INQUIRE ABOUT YOUR MEDICAL INFORMATION. PLEASE LIST THOSE INDIVIDUALS TO WHOM THE INFORMATION MAY BE DISCLOSED:

| NAME(S) | RELATIONSHIP |
|---|---|
| ______________________________ | ______________________ |
| ______________________________ | ______________________ |
| ______________________________ | ______________________ |

I hereby acknowledge that I have received a copy of Chernoff and Associates, Cosmetic Surgeons Notice of Privacy Practices.

Signature: ____________________________________________

Printed Name: ________________________________________

Date: _______________________________________________

IMPORTANT:
If you are completing our new patient paperwork at home, 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.

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# PHOTO AND VIDEO RELEASE FORM

I grant permission to Chernoff Cosmetic Surgery to use my video, interview, and photos for the following purposes:

____ Educational Purposes: I understand photographs, interviews, or videos of me will be used for educational or informational presentations and/or publications, as well as before and after gallery for potential patient review.

____ All Media: I understand photographs, interviews, or videos of me will be used in any print media such as newspapers, informational brochures, educational films and television, and on the Chernoff Cosmetic Surgery website. I also understand that my photos will be used on any form of social media (Facebook, Instagram, Twitter, LinkedIn.) through the Chernoff Cosmetic Surgery accounts.

By signing this form, 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.

Name______________________________________________________________
Email
Address____________________________________________________________
Signature_________________________________________
Date______________________

If this release is obtained from a presenter under the age of 18, then the signature of that presenter's parent or legal guardian is also required.
Parent or Guardian's Signature______________________________________________________
Parent or Guardian's Name Printed____________________________________ Date______________

____ I do NOT grant Chernoff Cosmetic Surgery permission to use any photographs, interviews, or videos of me for any of the above, and wish for my photos to be used for chart purposes only.
Name _________________________________________
Date_____________________

*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.*

IMPORTANT: IF YOU WOULD LIKE TO CHANGE YOUR PERMISSION STATUS FOR PHOTO CONSENT:
1.) EMAIL info@drchernoff.com WITH YOUR NAME AND REQUEST TO CHANGE YOUR PHOTO STATUS.
2.) SEND A LETTER BY MAIL TO 9002 N Meridian St. Suite 205 Indianapolis, IN 46260 WITH YOUR REQUEST.