# 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 UNDER 18: Provide *Parent/guardian name & address (if address is different than above)*

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Spouse Name _____ Spouse Phone Number_____

Your Employer _____Spouse Employer _____

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

NAME: _____ RELATIONSHIP: _____

PHONE: _____

Address of Relative _____

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### How did you hear about us?

- ☐ Website (drchernoff.com)
- ☐ Social Media
- ☐ TV
- ☐ Radio
- ☐ Friend or Relative *(provide name)*_____
- ☐ Doctor or Medical Office *(provide name)*_____
- ☐ Salon or Spa *(provide name*_____
- ☐ Other *(provide name*_____

**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:

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Primary Doctor: _____ Phone: _____

Pharmacy Name _____ Pharmacy Phone:_____

Pharmacy Address: _____

**ALLERGIES**: ☐ Yes ☐ No If yes, list allergy type and reaction: *(environmental, chemical or food)*

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**MEDICATIONS**: ☐ Yes ☐ No (prescription and non-prescription) If yes, provide list and dosage:

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**Supplements, Homeopathic, & Vitamins:** **Skincare Products Used:**

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Alcohol: ☐ Y ☐ N Type: ☐ Wine ☐ Beer ☐ Liquor Frequency _____

Smoking ☐ Y ☐ N If yes, ☐ Vape ☐ Nicotine ☐ Cannabis Frequency _____

History of/or current drug use: ☐ Y ☐ N If yes, specify: _____

**All Previous Surgeries & Year**

**Are You Happy With Your Results? ☐ Y ☐ N**

If no, why not:

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**All Previous Cosmetic Treatments & Year**

**Are You Happy with Your Results? ☐ Y ☐ N**

If no, why not:

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Chernoff Cosmetic Surgery - MEDICAL HISTORY (continued)

**FAMILY MEDICAL HISTORY:**

| | Y | N | | | Y | N |
|---|---|---|---|---|---|---|
| Cancer | ☐ | ☐ | | Adverse reactions with anesthesia | ☐ | ☐ |
| Autoimmune diseases | ☐ | ☐ | | Thick or abnormal scaring or keloids | ☐ | ☐ |
| Bleeding or genetic disease | ☐ | ☐ | | Diabetes | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | | High Blood Pressure | ☐ | ☐ |
| Stroke | ☐ | ☐ | | Other _____ | ☐ | ☐ |

**PERSONAL MEDICAL HISTORY:**

| | Y | N | | | Y | N |
|---|---|---|---|---|---|---|
| Breastfeeding | ☐ | ☐ | | Antibiotics in last 14 days | ☐ | ☐ |
| Eye Conditions | ☐ | ☐ | | Sun Sensitivity | ☐ | ☐ |
| Contact Lenses | ☐ | ☐ | | Hypo/Hyper Pigmentation | ☐ | ☐ |
| Incomplete Opening/Closing Eyes | ☐ | ☐ | | Active Acne / Acne Scaring | ☐ | ☐ |
| Teeth Implants | ☐ | ☐ | | Accutane in last 6 months | ☐ | ☐ |
| Dentures | ☐ | ☐ | | Cold Sores / Fever Blisters | ☐ | ☐ |
| Surgical Implants / Devices | ☐ | ☐ | | Rosacea | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | | Skin Conditions | ☐ | ☐ |
| Adverse reaction to Anesthesia | ☐ | ☐ | | Kidney Conditions | ☐ | ☐ |
| Bodily Injury | ☐ | ☐ | | Neurological conditions | ☐ | ☐ |
| Chronic Pain | ☐ | ☐ | | Facial or Neck Weakness | ☐ | ☐ |
| Diabetes | ☐ | ☐ | | Difficulty Swallowing | ☐ | ☐ |
| Cancer | ☐ | ☐ | | Seizures | ☐ | ☐ |
| Skin Cancer | ☐ | ☐ | | Sleep Apnea | ☐ | ☐ |
| Abnormal Scaring/Keloids | ☐ | ☐ | | High Blood Pressure | ☐ | ☐ |
| Open Wounds | ☐ | ☐ | | Bleeding / Clot Disorder | ☐ | ☐ |
| Current Infection | ☐ | ☐ | | Genetic Disease | ☐ | ☐ |
| HIV | ☐ | ☐ | | Arthritis | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | | Liver Condition | ☐ | ☐ |

If Yes to any of the above, please specify_____

Currently pregnant: ☐Yes ☐No Breastfeeding: ☐Yes ☐No Last Menstrual Period:_____

Number of pregnancies_____ Number of births_____Contraception Type:_____

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

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

CHERNOFF
COSMETIC SURGERY

**NO SHOW & CANCELLATION POLICY**
We are often on a waiting list for appointments. To allow patients on our waiting list appointments, we kindly ask that you give **3 business days** (M-F) if canceling or changing an appointment. In the event of less than 3 business days or a "no show," you will be charged $100. If you are a New Patient, the Consultation Fee Policy will apply.

**PAYMENT FOR COSMETIC PROCEDURES**: All in office 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_____

CHERNOFF
COSMETIC SURGERY

**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: _____

VIEW PRIVACY POLICY

IMPORTANT:
If you are completing our new patient paperwork at home and cannot view the privacy policy, 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.