

## PATIENT REGISTRATION FORM

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(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Social Security No.	Home phone	Cell phone			Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Drivers License #:			State:	Exp Date:			
Email address:							
Street Address:		City:			State:	ZIP Code:	
<b>How did you hear about CosmetiCare?</b>				<input type="checkbox"/> Drove by	<input type="checkbox"/> Current patient	<input type="checkbox"/> Another physician	
<input type="checkbox"/> Television	<input type="checkbox"/> Email	<input type="checkbox"/> CosmetiCare.com	<input type="checkbox"/> Magazine/Newspaper Which one? _____		<input type="checkbox"/> Internet Search Engine Which one? _____		

### EMPLOYER INFORMATION

Employer Name:	Occupation:
Employer's Address:	Employer Phone:

### IN CASE OF EMERGENCY

Name of Person to Contact:	Relationship:
Phone #:	

### CONTACT METHODS

We contact our patients periodically to provide appointment reminders, to ask questions, to get patient feedback about the services they have received, and to offer our patients new products, services, and promotions. If you would like to opt out from CosmetiCare communication, please check the following boxes to indicate you do not wish to receive communication via:

Email     
  USPS Mail     
  Cell Phone     
  Home Phone     
  Text Message

### PURPOSE OF VISIT

Please briefly describe the purpose of today's visit:

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By signing below, I understand that I am financially responsible for all charges including collection, legal or any other costs incurred should they be necessary on my account because of non-payment.

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Patient Signature	Date
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## PATIENT REGISTRATION FORM: INSURANCE INFORMATION

Patient Name:	Date:
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### INSURANCE

**PRIMARY HEALTH INSURANCE COMPANY:**

Policy #:	Group #:	Ins. Phone:
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Referral Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Copay? <input type="checkbox"/> Yes <input type="checkbox"/> No	Copay Amt: \$
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<b>Insured:</b> Name	DOB:	Employer:
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**SECONDARY HEALTH INSURANCE COMPANY:**

Policy #:	Group #:	Ins. Phone:
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Referral Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Copay? <input type="checkbox"/> Yes <input type="checkbox"/> No	Copay Amt: \$
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<b>Insured:</b> Name	DOB:	Employer:
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**By signing below, I authorize this office to release to the named insurance companies any information necessary to expedite insurance payment. I understand that I am financially responsible for all charges including collection, legal or any other costs incurred should they be necessary on my account because of non-payment, regardless of insurance coverage.**

Patient Signature	Date
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### COSMETIC INTEREST QUESTIONNAIRE

Patient's Last Name:	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Date of Birth:
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	

(Please check all that apply.)

Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information and services you desire on the health and appearance of your skin and body, we invite you to complete the following questionnaire.

<input type="checkbox"/> Lines around my eyes (crow's feet)	<input type="checkbox"/> Crease nose to corner of mouth (parenthesis lines/naso labia folds)
<input type="checkbox"/> Lines between my eyes (angry look)	<input type="checkbox"/> Frown on corner of mouth (marionette lines)
<input type="checkbox"/> Lines on forehead	<input type="checkbox"/> Brown spots on face
<input type="checkbox"/> Lines under eyes	<input type="checkbox"/> Red, blotchy skin
<input type="checkbox"/> Puffy eyes	<input type="checkbox"/> Excess skin above eyes
<input type="checkbox"/> Thin lips	<input type="checkbox"/> Thin face, no cheeks
<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Dimpled Chin
<input type="checkbox"/> Oily Skin	<input type="checkbox"/> Gummy smile
<input type="checkbox"/> Sagging brows (looking tired)	<input type="checkbox"/> Sunk in eyes

Please check all of the following procedures about which you would like more information:

<input type="checkbox"/> Breast Enlargement	<input type="checkbox"/> Chin or Cheek Implants
<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Vaginal Reconstruction
<input type="checkbox"/> Breast Lift	<input type="checkbox"/> Weight Loss (Lap Banding)
<input type="checkbox"/> Liposuction (Body Contouring)	<input type="checkbox"/> Botox
<input type="checkbox"/> Tummy Tuck (Abdominoplasty)	<input type="checkbox"/> Fillers (Juvederm, Restylane, Sculptra)
<input type="checkbox"/> Nose Surgery (Rhinoplasty)	<input type="checkbox"/> Excessive Sweating (Hyperhidrosis)
<input type="checkbox"/> Eyelid Surgery (Blepharoplasty)	<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Facelift (Facial Rejuvenation)	<input type="checkbox"/> Medical Grade Skin Care
<input type="checkbox"/> Forehead/Brow Lift	<input type="checkbox"/> Permanent Make-Up
<input type="checkbox"/> Neck Lift	<input type="checkbox"/> Laser Facial Resurfacing
<input type="checkbox"/> Ear Reshaping (Otoplasty)	<input type="checkbox"/> Photo Rejuvenation/rosacea treatment
<input type="checkbox"/> Buttocks Augmentation	<input type="checkbox"/> Age Spots/Facial Pigmentation Problems
<input type="checkbox"/> Tattoo Removal	
<input type="checkbox"/> Other:	

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

## MEDICAL HISTORY

Patient's Last Name:	First:	Middle:	Date of Birth:	Height	Weight

*Please fill out the medical history as completely as possible.  
This is a confidential record and will be kept in your chart. No information will be released without your permission.*

**MEDICAL HISTORY:** If you **have or have had** any of the following, please indicate with "X".

<input type="checkbox"/> Diphtheria <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Ulcers <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease  <b>Gynecology</b> <input type="checkbox"/> Pregnancies <input type="checkbox"/> # of Live Births: _____ <input type="checkbox"/> # of Miscarriages: _____ <input type="checkbox"/> Menses Regular <input type="checkbox"/> Menses Irregular  <b>Head</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremors <input type="checkbox"/> Fainting  <b>Cardiovascular</b> <input type="checkbox"/> Chest Pains <input type="checkbox"/> Heart Attacks	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Palpitations <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Bleeding Tendencies <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis <input type="checkbox"/> Depression  <b>Neuromuscular</b> <input type="checkbox"/> Seizures <input type="checkbox"/> Loss of Equilibrium <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Joint Disorders <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Pain <input type="checkbox"/> Convulsions <input type="checkbox"/> Angina	<input type="checkbox"/> HIV Positive <input type="checkbox"/> Hepatitis <input type="checkbox"/> Anemia <input type="checkbox"/> AIDS  <b>Genito-Urinary</b> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Backache <input type="checkbox"/> Discharge <input type="checkbox"/> Difficulty in Urination <input type="checkbox"/> Jaundice <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Nervous Breakdown <input type="checkbox"/> Malaria <input type="checkbox"/> Venereal Disease <input type="checkbox"/> High Blood Pressure  <b>EENT</b> <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Double Vision <input type="checkbox"/> Poor Vision <input type="checkbox"/> Nasal Obstruct <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Postnasal Drip	<b>Respiratory</b> <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Night Sweats <input type="checkbox"/> Chest Pains <input type="checkbox"/> Weight Loss <input type="checkbox"/> Wheezing/Asthma  <b>Gastro-Intestinal</b> <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Lack of Appetite <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Chronic Indigestion <input type="checkbox"/> Black Stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Ulcer History <input type="checkbox"/> Bleeding <input type="checkbox"/> Acid Reflux
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If you have or have had any of the above, please describe: \_\_\_\_\_

### PAST MEDICAL HISTORY

Surgery (include all prior cosmetic procedures)	Year	Anesthesia (Local/General)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you experienced problems with local anesthesia?  Yes  No      General anesthesia?  Yes  No

### MEDICATIONS

Are you currently taking any medications?  Yes  No  
 If yes, please list **ALL medications** including homeopathic drugs:  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any drugs?  Yes  No      If yes, what? \_\_\_\_\_

Do you have a history of cancer in your family?  Yes  No      If yes, what type? \_\_\_\_\_

### SOCIAL HISTORY

Describe approximate daily consumption of:    Alcohol \_\_\_\_\_    Tobacco \_\_\_\_\_    Coffee \_\_\_\_\_

### RECENT EXAMINATIONS

Physical Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date _____	EKG: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date _____
Chest X-Ray: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date _____	Labs: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date _____
Mammogram: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date _____	



## South Coast Outpatient Surgery Center Anesthesia Associates

### PATIENT FINANCIAL POLICY & AGREEMENT

Patient has requested and received an estimated price quotation for surgical procedure(s) to be performed by a CosmetiCare plastic surgeon.

#### SURGERY DEPOSIT

Should patient choose to proceed with surgery, a \$500.00 (five hundred dollars) NON REFUNDABLE deposit is required to reserve your surgery date. This deposit is credited towards the surgery fee balance due, as illustrated in the estimated price quotation of your requested surgical procedure(s). *Cancellation of your reserved surgical date regardless of the notice given will result in the forfeiture of the \$500.00 NON REFUNDABLE deposit.*

#### CANCELLATION POLICY

Upon giving a surgery deposit, you understand that a surgery date has been reserved *specifically for you*, the patient. This involves the commitment of your surgeon, anesthesiologist, surgery center, recovery room team, surgical team and necessary surgery equipment & supplies to be reserved for the time period required to perform your surgical procedure(s) on the surgery date you (the patient) have chosen to reserve.

As such, you (the patient) acknowledge that any cancellation of the reserved surgery date less than 7 (seven) days prior to scheduled surgery date, is an insufficient period of time within which CosmetiCare, South Coast Outpatient Surgery Center, & Anesthesia Associates can re-schedule or schedule another patient for surgery to fill the cancelled time slot.

\*Therefore, any cancellation or postponement *initiated by the patient* with less than 7 (seven) days notice prior to the date of surgery will result in patient forfeiting all fees, including the \$500.00 deposit.

\*If cancellation or postponement of scheduled surgery date is initiated by the patient with at least 7 (seven) days notice prior to date of surgery, 50% (fifty percent) of surgery fees paid (excluding the \$500.00 deposit) will be refunded from CosmetiCare, South Coast Outpatient Surgery Center, and Anesthesia Associates.

NOTE: If surgical fees paid in full included the cost of implants, a refund for the implant cost will be issued to patient within 30 days.

#### PAYMENT SCHEDULE

After CosmetiCare has received your surgery deposit, all balances due for the surgical procedure(s) must be PAID IN FULL no later than your scheduled Pre-Operative appointment. **\*\*FAILURE TO PAY ALL BALANCES DUE UPON YOUR PREOPERATIVE APPOINTMENT WILL RESULT IN CANCELLATION OR RESCHEDULING OF YOUR RESERVED SURGERY DATE.**

#### ACCEPTABLE METHODS OF PAYMENT

We accept Cash, Cashier's Checks, Money Orders, and Major Credit Cards. Personal Checks and Debit Cards are NOT accepted for balances due.

I HAVE READ AND UNDERSTAND THE OUTLINED PATIENT FINANCIAL POLICY AGREEMENT PROVIDED BY COSMETICARE, SOUTH COAST OUTPATIENT SURGERY CENTER, AND ANESTHESIA ASSOCIATES.

\_\_\_\_\_  
PATIENT SIGNATURE

(Parent or guardian signature if patient is a minor)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE



## Health Care Disclosure Notification

Dear Patient:

Effective April 14, 2003, the Federal Health Privacy Rule must be implemented and we must inform our patients of their rights under this law.

While we have always made every effort to keep all your information confidential, we are now required to inform you of those persons or entities who may have access to your personal and health care information.

1. Employees of CosmetiCare and South Coast Outpatient Surgery Center (limited by job classification)
2. Physicians associated with your treatment or surgical procedure
3. Outside physicians or pathologist who would examine tissue removed
4. Anesthesiologist associated with the Surgery Center
5. Any physician or hospital to whom you are referred by our staff physicians
6. Any independent contractor working with CosmetiCare, i.e. consultants and aestheticians
7. Any independent contractor working with South Coast Outpatient Surgery Center, i.e. , registered and licensed vocational nurses and technologists.
8. Your health insurance provider
9. Designated family members or friends (post surgical)
10. Accrediting agencies
11. Medical staff committees for the purpose of quality assessment and peer review
12. Licensing agencies in response to inquiries
13. Issuance of a subpoena and upon verification of authorization
14. Research - patients who are participating in a clinical study

ALL PATIENTS WILL BE REQUESTED TO SIGN A CONSENT PRIOR TO TREATMENT.

### **Patient's Rights**

1. Patient has the right not to sign consent. However, this would necessitate the physician to refuse treatment.
2. A patient has the right to revoke the consent after receiving treatment.
3. Patient has the right to request restrictions and request confidential communication.
4. Patient has the right to examine and review his or her health information upon written request. This request will be honored within five (5) working days.
5. Patient has the right to request a copy of his or her health information upon written request. The copy will be completed within 15 days of receiving request at a cost to the patient of \$ 0.25 per page.
6. Patients have the right to request an amendment to their health information and, if accepted, this will become a part of the complete medical record. Information and procedure to be followed can be received by contacting April Lee at extension 255.
7. Patients who feel their privacy with regards to personal or health care information has been compromised may contact:
  - a. April Lee, in this office, at extension 255
  - b. Department of Health and Human Services
  - c. Office of Civil Rights

NOTICE: By signing this notification you are agreeing that you have been notified of the Federal Health Privacy Rule now in effect.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature: Patient or Patient's Representative

\_\_\_\_\_  
Date



## CONSENT FOR THE DISCLOSURE OF HEALTH AND PERSONAL INFORMATION

You have already received our Disclosure Notification, which made you aware of the persons and entities whom could possibly have access to your medical information for the purposes of treatment, payment, and health care operations.

As stated in the Notification, you have the right to request restrictions or revoke your consent. If you have any further questions or need clarification, please discuss with a member of our staff.

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I consent for the use of my medical/personal information to be used for the purposes outlined in the Disclosure Notification.

I have restrictions:  Yes  No \_\_\_\_\_ Initial

Please list any restrictions below:

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Restrictions Approved by Provider:  Yes  No \_\_\_\_\_ Initial

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I have read and understand the foregoing Consent for Disclosure.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature: Patient or Patient's Representative

\_\_\_\_\_  
Date