Center for Facial and Body Rejuvenation
Patient Information

Name: _____ Sex: M F
Last First MI

Home Address: _____
Street Apt. City State Zip Code

Phone: _____ _____ _____
Home Work Cell

E-Mail: _____

Birth Date: _____ Age: _____ Marital Status: S M D W Name of Spouse: _____

Allergies _____

Referral Information

How were you referred? (Check all that apply)

□ Patient Name: _____ □ Friend: Name: _____
□ Physician/Dentist: _____ □ Nurse: Name: _____
□ Newspaper □ Radio □ Yellow Pages □ Magazine: Name: _____
□ Other Source: _____

Patient Employment Information

Employers Name: _____ Occupation: _____

In case of emergency

Please list name, phone number, and relationship of person to contact:

Name: _____ Phone numbers: _____
Relationship to Patient: _____
Family Physician: _____ Address: _____ Phone #: _____

CONSENT TO TREAT/INSURANCE AUTHORIZATION/RELAEASE OF INFORMATION

I consent to treatment as necessary or desirable in the care of the patient named above, including, but not restricted to, whatever drugs, medicine, performance of procedures, and conduct of laboratory, x-ray, or other studies deemed necessary by Dr. Cheng and his/her qualified designate. I authorize the exchange of information with any medical providers participating in my care.

FINANCIAL RESPONSIBILITY

I recognize and accept full financial responsibility for all professional services rendered, regardless of the amounts covered by any applicable insurance coverage. In the event Center for Facial And Body Rejuvenation is required to collect my account after default, I will be responsible for all attorney fees and cost of collection. If insurance is to be filed, I authorize release of medical information including photographs necessary to process any claim for services provided by Center for Facial And Body Rejuvenation .I further authorize an insurance company to pay benefits directly to Center for Facial And Body Rejuvenation.

Date: _____

_____
Signature of Patient/Responsible Party

_____
Relationship to Patient/Minor

Center for Facial and Body Rejuvenation

Historical Data Sheet

Patient Name: _____
Last First MI

Date of birth: _____ Age _____ Height: _____ Weight: _____

Reason(s) for seeing physician: _____

In what surgical procedure are you interested?

___Rhinoplasty (nose)	___Forehead Lift	___Removal of moles or lesions
___Eyelids	___Face or Neck Lift	___Botox/Injectable filler
___Chin	___Scar Revision	___Repair of torn earlobe
___Protruding Ears	___Skin Resurfacing	___Laser Hair Removal
___Liposuction	___Eyelash Transplant	___Hair Transplantation

Other: _____

Have you consulted another doctor in regards to this type of surgical procedure? _____
If so whom? _____

Please list **all medications, vitamins, or supplements** you are currently taking (including birth control, hormones and natural dietary supplements): _____

Previous surgeries (including cosmetic): _____

Describe any complications you may have experienced: _____

Any known allergies? __Yes __No Please list: _____

Are you allergic to latex gloves? ___Yes ___No

Have you taken steroid within the past year? ___Yes ___No

Do you take aspirin and/or baby aspirin, regularly? __Yes __ No

---

Family doctor / Internist: _____ Address: _____

OB/Gyn? _____ Address: _____

Date of last physical exam: _____ May we notify him/her of your upcoming surgery?

If you are currently being treated by a psychiatrist or psychologist:

Name: _____ Phone number _____

Have any family members been affected by any of the following conditions?

____HeartDisease	____Poor Healing	____Excessive Bleeding
____High Blood Pressure	____Thyroid Disease	____Psychiatric or "nerve" problems
____Diabetes	____Reactions or complications to anesthesia	

Have you ever had any reaction to local or general anesthesia? ____yes ____no If yes, please describe:

Ever taken Accutane?	**__Yes ___No**	**If stopped, when?** _____
Caffeinated drinks:	**__Yes ___No**	**# per day** _____
Tobacco use:	**__Yes ___No**	**# packs a day____ If stopped, when?** _____
Use nicotine patch?	__Yes ___No	Does anyone in your household smoke? __Yes __No
Drink Alcohol?	**__Yes ___No**	**How many a day?** _____
Use Recreational drugs	**__Yes ___No**	**If so, what?** _____

Have you ever been treated or diagnosed with any of the following? Mark all that apply.

____ Rheumatic heart disease
____ High blood pressure
____ Heart attack
____ Hepatitis / Jaundice
Type: A __ B __ C __
____ HIV / (AIDS)
____ Psychiatric problems
____ Bleeding tendencies
____ Excessive scarring
____ Any eye problems

____ Cold sores / Fever blisters
____ Heart murmur
____ Hay fever / Nasal allergies
____ Anemia
____ Ulcers
____ Cancer
____ Staph infections
____ Easy bruising
____ Latex allergy
____ Skin condition, infection, irritation
Other: _____

____ Stroke
____ Angina / Chest pain
____ Lung / Chest problems
____ Asthma
____ Lupus / Scleroderma
____ Depression
____ Seizures / Convulsion
____ Diabetes
____ Alcohol / Drug dependency
____ Thyroid problems

Have you been told to take antibiotics prior to getting your teeth cleaned by the dentist? ___Yes ___No

Do you have any other medical problems that have **not** been covered? _____
If so please explain: _____

Do you realize that every operation is followed by a period of healing before the tissue returns to normal and a final result is apparent? ___Yes___No

Do you understand that the objective of any cosmetic surgery is improvement in appearance, ***not perfection***?
___Yes ___No

Female Patient Only

Are you pregnant? ___Yes ___No
Number of past pregnancies: _____

Date of last menstrual period: _____
Number of live births: _____

Please list any other additional information you think is or would be important for us to know about your medical or social history prior to your surgery. Do you have any specific or unique questions you want answered?

_____
_____
_____

Confidential Record*: Information contained here* ***will not be released*** *unless you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in making decisions regarding your care.*

I authorize my physician and/or administrative and clinical staff to telephone or otherwise contact me (or the responsible party) regarding appointments, treatment information, or any other details related to patient therapy and treatment.

Signed: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Center for Facial and Body Rejuvenation
Elbert T. Cheng, M.D, and Jacqueline T. Cheng, M.D
12945 Saratoga Ave, Saratoga CA 95070
(408) 255- FACE (3223)

I hereby acknowledge that I was made aware of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I was offered a copy of the Notice of Privacy Practices and of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____