

Renuance Cosmetic Surgery Center
Brian Eichenberg M.D., Board Certified Plastic Surgeon

Please complete these forms so we can provide the best care possible in helping you achieve your goals.

Reason for Visit? _____

Last Name: _____ First Name: _____ M.I. _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ E-MAIL ADDRESS: _____
Where & When is the best time to call: _____
Date of Birth: _____ Age: _____ Sex: _____
Marital Status: Single Married Divorced Widow(er)
Social Security #: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Relation: _____ Phone: _____
How did you hear of us: _____

Spouse/Parent Information

If Minor, Relationship: _____

Last Name: _____ First Name: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____

Insurance Disclaimer

Dr. Eichenberg's office is currently not billing any insurance companies. However, under special circumstance, we can provide you with all the necessary information to bill your insurance company yourself. Unless you know your insurance company will be billed for your services at Dr. Eichenberg office, it will be up to the patient and/or guardian to provide insurance information.

I assign directly to Brian J.Eichenberg, M.D. and all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits.

Signed: _____ Date: _____

Tell us about you!!

Do you have any questions for our Medical Spa? _____

What are your 2 favorite radio stations? _____

Name 3 things you like: _____

Do you read any local magazines? _____

Medical History

Patient Name: _____ Date of Birth: _____

Please answer all of the questions as accurately as possible. If you do not understand the question please ask for assistance.

Primary Care Physician: _____ Phone : _____

Smoking (type & amount per day): _____ If former, Date Quit: : _____

Alcohol (type & amount per week): _____

Weight: _____ Height: _____

Drug allergies: _____

Previous surgeries & dates: _____

List any medications you are taking, including non-prescription drugs, vitamins and herbs: _____

Has any blood relative ever had the following:

Breast Cancer.....no yes High blood pressure.....no yes Depression.....no yes Melanoma.....no yes

Heart disease.....no yes Kidney Disease.....no yes Stroke.....no yes Diabetes.....no yes

Please circle if you have ever had the following:

Heart disease Cancer Stomach ulcer Arthritis Glaucoma Kidney disease Asthma

Rheumatic Fever Thyroid disease Anemia AIDS or HIV+ Stroke Diabetes Hepatitis Tuberculosis

Bleeding tendency Mitral valve prolapse High Blood Pressure Other Illness: _____

Please circle if you do have now or have had within the past year:

Weight change Swollen feet/ankles Seizures Dry Eyes Skin Rash Joint or Muscle Pain

Chronic cough Chronic diarrhea Swollen lymph nodes Chest Pain Jaundice Easy Bruising

Easy Bleeding Rapid heart beat Depression

WOMEN ONLY: Number of pregnancies: _____ Currently Breast Feeding? _____

Date of last mammogram: _____ Was it normal? _____

Do you do regular breast self-examinations?...no yes Breast lump or discharge?.....no yes

I certify that, to the best of my knowledge, the above represents my current medical status (failure to disclose any information releases my physician from any harm that may result from this lack of knowledge.)

Signature: _____ Date: _____

Dr. Signature: _____ Date: _____

*Cosmetic Interest
Questionnaire:*

*Renuance Cosmetic Surgery
Center*



Name:

Date:

What Are Your Areas Of Concern?	Please Check	Are you interested in learning about the following?	Please Check
Frown lines between the brows		Botox Cosmetic	
Lines around the nose and mouth		Juvederm/Restylane-Injectable Gels	
Latisse		Acne/Acne Scarring	
Facial Hair		Laser Resurfacing (Fraxel or CO2 Laser)	
Acne		Obagi Skin Care	
Freckles		Spider Vein Removal	
Fine lines and wrinkles		Hair Removal	
Rough skin texture		Microdermabrasion	
Sagging Skin		Thermage	
Hyperpigmentation		Sun Damage/Age Spot Removal	
Dark Circles Under Eyes		Liposuction	
Dry Skin		Breast Surgery	
Loss of Volume in the Lip Area		Facial Surgery	
Physical Appearance		Body Surgery	
Moles on the body		Mole Removal	
How Did You Hear About Us? (Specify)	Questions about the office		Y or N
Friend:	Was the staff courteous on the phone?		
Patient:	Did you get an appointment when you wanted?		
Insurance Company	Were all your questions answered when you called?		
Seminar:	Were you greeted in a professional manner during today's appointment?		
Ad:			
Physician:	Did you wait long to see the nurse or doctor?		
Internet (Search Engine):	Was the office in acceptable appearance?		
Radio:	Would you recommend us to a friend or relative?		
Other:	Other (Suggestions):		

Consent for Purposes of Treatment, Payment & Healthcare Operations

Brian J. Eichenberg, M.D., APC and Renuance Aesthetic Care, Inc

Although this form is no longer required for HIPPA compliance, you are being asked to sign this form because it IS REQUIRED for the State of California and/or other compliance.

Consent

I consent to the use or disclosure of my protected health information by Brian J. Eichenberg, MD for the purpose of diagnosing me or providing treatment to me, for obtaining payment for my health care bills, or to conduct the health care operations of Brian J. Eichenberg, MD APC & Renuance Aesthetic Care, Inc. I understand that diagnosis or treatment of me by Brian J. Eichenberg, MD may be dependent upon my consent as evidenced by my signature on this document.

RESTRICTION ON THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION

I understand I have the right to request that Brian J Eichenberg, MD restrict the way my protected health information is used or disclosed in order to treat me, to obtain payment , or for the other healthcare operations of this facility. Brian J Eichenberg, MD is not required to agree to the restrictions that I may request. However, if Brian J Eichenberg, MD does agree to a restriction that I request, the restriction is binding on this facility and its staff.

REVOKE CONSENT

I have the right to revoke this consent, in writing, at any time, except to the extent that Brian J. Eichenberg, M.D. or this facility already has taken action based upon this consent.

DEFINITION OF PROTECTED HEALTH INFORMATION

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES

I understand I have a right to review Brian J. Eichenberg, M.D.'s Notice of Privacy Practices prior to signing this document. Dr. Eichenberg's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Brian J. Eichenberg, M.D and Renuance Aesthetic Care.

Brian J. Eichenberg, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices to better protect your personal information. I understand that I can obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to me in the mail or by asking for a revised notice at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative