Renuance
COSMETIC SURGERY CENTER

Brian Eichenberg, MD
Zachary Filip, MD
Board Certified in Plastic Surgery

Welcome

Please PRINT in blue or black ink.

First Name: ______________________ Last Name: ____________________ M.I. _______

Home Address: ____

City: ______________________________ State: ______ Zip: ____________

Phone: ______________________ Email: ______________________________

Date of Birth: _____/_____/_____ Age: _____ Sex: F M

If patient is a minor, or unable to complete documents, please give parent or guardian information:

Last Name: ____________________ First Name: ______________________ M.I.________

Phone Number: __________________ Relation: ______________________________

How did you first hear of us (*circle one*)? Internet search Internet Ad/Banner Yelp! Facebook

RealSelf Billboard YourVilla Magazine Inland Empire Magazine Temecula Valley Hospital

Other: ____________________

Or a friend or family member? Who may we thank? ______________________________

Reason for today's visit: ____

Are there any additional *areas* you would like to discuss (*circle any*)?

Breasts	Abdomen/waist	Arms	Thighs	Buttocks
Neck	Cheeks/jowls	Lips	Eyes	Forehead
Wrinkles	Sun Damage	Dark spots	Scars	Loose facial skin
Acne	Laser hair removal	Spider veins	Other: ____________	

Are there any additional *products* you would like to know more about (*circle any*)?

Botox	Juvederm	Voluma	Latisse	Obagi	Kybella
VI Peel	TCA peel	CO2 Laser	Sublative	Sublime	Photofacial
TNS Serum	Lytera	Skinmedica	Fat grafting/transfer	New “Gummy Bear” Breast Implants	

Are you a Brilliant Distinctions® Loyalty Program Member (*circle one*)? YES NO

May we provide you with information on ways to save on products and treatments (*circle one*)? YES NO

____________________ ____________________

Initials Date

MEDICAL HISTORY FORM

Patient Name ______________________ Date of Birth ______________________

Emergency Contact ______________________ Phone Number ______________________ Relation ______________________

Primary Care Physician ______________________ Phone Number ______________________ Date of Last Visit ______________________

Medical Insurance Carrier ______________________ Policy Number ______________________ Claims Phone Number ______________________

Employer ______________________ Occupation ______________________

Height __________ Weight __________

Do you use Tobacco? YES NO If yes, amount/day __________

Do you drink alcohol? YES NO If yes, amount/week __________

Do you exercise regularly? YES NO Are you able to comfortably climb 2 flights of stairs? YES NO

MEDICATIONS *(please list ALL prescriptions, vitamins, supplements, over-the-counter medications, and birth control)*

____

____

ALLERGIES *(please list with type of reaction)* ______________________________

SURGICAL HISTORY *(please list ALL surgeries and approx. year)* ______________________________

____

Any complication (*circle any*)? infection bleeding blood clot severe vomiting other: __________

MEDICAL HISTORY *(please circle ANY of the following conditions past or present)*

Heart Disease Heart Valve Atrial fibrillation Cancer __________ Breast Mass Stomach Ulcer Reflux/heartburn Hernia Kidney Disease Stroke/TIA Migraine Seizures Blood Clot Bleeding Disorder High Blood Pressure Anemia Hepatitis AIDS/HIV+ MRSA Diabetes Thyroid Disease Sinus Infection Asthma COPD Sleep Apnea Seasonal Allergies Dry eyes Glaucoma Arthritis Anxiety Depression Major Injury / hospitalization: __________

Other: ______________________________

FAMILY HISTORY *(please circle ANY or list any diseases affecting family members)*

Breast Cancer Malignant Hyperthermia Blood clot Bleeding disorder High blood pressure Heart Disease Diabetes Cancer Unexpected death due to anesthesia Other: __________

REVIEW OF SYSTEMS *(please circle ANY NEW symptoms you have had within the past year)*

Unexplained weight change Frequent fevers Frequent headache Memory difficulty Seizures Dry Eye Vision change Swollen lymph nodes Chest pain Shortness of breath Palpitations Wheezing Cough Abdominal pain Chronic Diarrhea Blood in stool Easy bleeding Jaundice Easy bruising Joint pain Skin rash Feeling hopeless Feeling overly nervous Other: __________

______________ ______________

Initials Date

MEDICAL HISTORY FORM (continued)

FOR WOMEN CONSIDERING BREAST PROCEDURES (circle yes or no):

Have you ever had a mammogram?	YES	NO	If yes, date ______________
Have you ever had an abnormal mammogram?	YES	NO	
Have you ever had a breast biopsy?	YES	NO	
Have you breast fed in the past 3 months?	YES	NO	
Do you anticipate becoming pregnant in the future?	YES	NO	

SPECIAL CONSIDERATIONS (circle yes or no):

Have you ever had an electrocardiogram (ECG)?	YES	NO
Have you or any family member had a severe reaction to general anesthesia?	YES	NO
Have you had a bad reaction to local anesthesia for a dental procedure?	YES	NO
Do you use a CPAP machine?	YES	NO
Do you have any allergies to adhesive tape?	YES	NO
Are you sensitive to latex?	YES	NO
Are you a slow or poor healer?	YES	NO
Do you form large scars or keloids?	YES	NO
Have you ever taken any steroid medications such as prednisone?	YES	NO
Have you taken any oral retinol medications such as Accutane?	YES	NO
Do you have any back or joint pain or limitations in movement?	YES	NO
Do you have a medical condition or information not revealed elsewhere on this form?	YES	NO

If so please describe below:

____

____

____

____

____

I certify to the best of my knowledge that the above represents my current and complete condition without omission. I understand that failure to disclose any information releases my surgeon from any harm that may result from this lack of knowledge.

Patient, Parent or Guardian Signature: ____

Please Print Name:______________________________ Date: __________________

POLICIES & DISCLOSURES

HEALTH INSURANCE

Renuance Cosmetic Surgery Center does not generally accept medical insurance as payment. Any fees potentially covered by insurance will be clearly indicated. For certain covered conditions we may be able to provide you with documentation for the purpose of you obtaining a benefit from your insurance. The maximum allowable benefit paid by most insurances is usually less than Renuance Cosmetic Surgery Center's charges. Under some circumstances Renuance may bill your insurance for specific fees associated with surgery, such as those for surgical pathology, and Renuance will keep that benefit.

PROTECTIVED HEALTH INFORMATION DISCLOSURE

By signing below you consent to the use or disclosure of your protected health information by Renuance Cosmetic Surgery Center for the purpose of law enforcement, obtaining payment, or conducting operations. You have the right to revoke this consent, in writing, at any time, except to the extent that Renuance already has taken action based upon this consent. You have the right to request that Renuance restrict the way your protected health information is used or disclosed. Renuance is not required to agree to the restrictions that you request.

PHOTOGRAPHS

By pursuing treatment at Renuance Cosmetic Surgery Center you give permission for associates and/or staff to take photographs of parts of your body in connection with the procedure(s) and/or treatment(s) being discussed and to use those photographs for medical treatment and professional medical purposes, including but not limited to: medical education, accreditation, certification, research, medical professional seminars and lectures, and publication in medical journals and books. Renuance also occasionally uses patient photographs for purposes of public education and marketing, including but not limited to: websites, social media, office photograph books, brochures, other internet exposure, and other advertising media. Patients are not entitled to compensation for use of these images. You may decline public education or marketing use of photographs by initialing here: ____

DISPUTES

Should a dispute arise, by signing below you agree to pursue appropriate avenues of recourse and not engage in negative comments against Renuance Cosmetic Surgery Center, its associates, and/or staff through any media or forum. In the event of failed legal action against Renuance you agree to compensate Renuance for its time and expense in defending against such action.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes the types of uses and disclosures of your protected health information that will occur in your treatment, billing, and operations of Renuance Cosmetic Surgery Center. You have a right to review the Notice of Privacy Practices prior to signing this document and a copy is available to you. Renuance reserves the right to change the Notice of Privacy Practices. You may request a revised Notice of Privacy Practices.

EMERGENCIES

By signing below you agree that Renuance Cosmetic Surgery Center physicians may order medically necessary care during an emergency that was not previously planned or discussed. You will be be financially responsible for the cost of that care and shall not seek reimbursement from Renuance.

I have read and understand the above policies and disclosures.

Patient, Parent or Guardian Signature: ____

Please Print Name:________________________________ Date: __________________