Patient Information

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

Name: ____ Sex: M F
Last First MI

Home Address: ____
Street Apt. City State Zip Code

Phone: ____________________ ____________________ ____________________
Home Work Cell

E-Mail: ______________________________ □ Please contact me by email to inform me about special offers

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 □ TV: Network: ________________
□ 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 #: ____________

Do you have an Advanced Directive? □ Yes □ No

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