Renaissance Center for Facial and Body Sculpting

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid Spouse's name:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security #: — —	Birth date: / /	Age:	Sex: ❑ M ❑ F

Email:	Cell phone no.: ( )	Home phone no.: ( )

Mailing address:	Suite/Apt:	City	State	Zip Code:

Occupation:	Employer:	Employer phone no.: ( )

How did you hear about Dr. Nygaard? (please check one box): ❑Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family/ Friend ❑ TV ❑ Seminar ❑ Web ❑ Salon ❑Magazine ❑ Other

Referred friend/family name:	May we thank them? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Mobile/Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Nygaard to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Nygaard and myself.

______________________________ ______________________________

Patient/Guardian signature *Date*

Renaissance Center for Facial and Body Sculpting

REGISTRATION FORM

(Please Print)

Today's date:

INSURANCE INFORMATION					
(Please give your insurance card to the Front Desk upon check-in)					
Patient's Name:					
Birth date: / /	Address (if different):		Best contact no.: ( )		
Is this patient covered by insurance?	❑ Yes ❑ No				
Primary Care Provider:					
Primary Insurance Company:					
Policyholder's name:	Policyholder's S.S. no.: — —	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self ❑Spouse ❑ Child ❑ Other				
Does this insurance require a referral?	❑ Yes ❑ No				
Secondary Insurance Company:					
Policyholder's name:	Policyholder's S.S. no.: — —	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Policyholder's name:	Policyholder's S.S. no.:	Birth date: / /	Group no.:		
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other				
Does this insurance require a referral?	❑ Yes ❑ No				
Is this visit due to any type of accident? ❑ Yes ❑ No Date of Accident:____________________________					
Type of Accident ❑ Auto: State? _________ ❑ Work Related ❑ Other: __________________________					

All Insurance Patients—Signature of File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the about listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary signature *Date*

INSURANCE INFORMATION

When appropriate, we will prepare and submit insurance forms on your behalf. However, responsibility for payment lies within the individual patient. Balances carried over 30 days will accrue interest charges of 1. 5 % of the outstanding balance per month.
Deposits are required for certain procedures in order to schedule operating time, special technical personnel, and to obtain special supplies, implants or equipment. Deposits are not refundable. Full payment is due three to four weeks prior to the date of surgery at your preoperative appointment. Fees are determined and paid for the performance of a surgical procedure, not a guaranteed result. If complications occur, additional charges may be expected. Implants maybe warranted by the manufacturer, but this office does not provide additional warranty or assurance against implant defect or malfunction, or cover the additional costs incidental to reoperation and or replacement.

The patient's signature below certifies that the information provided herein is complete and accurate.

Signature of patient or responsible guardian *Date*

Renaissance Center

for Facial and Body Sculpting

Christine E. Nygaard, M.D.

Cascade Medical Center
1414 116th Avenue NE
Suite C
Bellevue, WA 98004
(425) 646-7472 • Fax (425) 453-1123

The information contained herein is confidential. We will neither release nor confirm anything disclosed on this form, including the fact that you are a patient of this practice, without your written permission.

Patient Information

1. Legal Name____
2. How would you like us to address you? ____
3. Best contact number ____

Medical History

1. Who is your personal or primary physician? ____
2. May we contact your physician? ____
3. Office Location and phone number ____

   ____

   ____

4. What is your height? ____________________ Weight ________________________
5. Please list all medical conditions or illnesses for which you have been treated within the past ten years.

   ____

____

____

6. Please List all operations and hospitalizations with dates.

____

____

____

7. Have you had complications following any procedure? Yes _________ No _________

   If so, please explain ____

   ____

   ____

8. Please list all medications you are currently taking or have taken within the past year including dosages.

____

____

9. Please list allergies, including drugs and adhesive tapes.

____

____

10. What kind of reaction occurs?

____

____

11. What is your approximate daily consumption of the following?

    Aspirin ______________________________

    Anti-inflammatories (Aleve, Advil, etc.) ______________________________

    Caffeine (coffee, tea, cola) ______________________________

    Alcohol ______________________________

    Tobacco ______________________________

12. Have you had a significant history of sun exposure? ______________________________________

13. Have you seen a psychologist, psychiatrist or counselor? ____________________________________

    If yes, reason or circumstances ____

    Name of psychiatrist of counselor ____

14. What medical illnesses run in your family (including, but not limited to: high blood pressure, stroke, heart disease or heart attack, diabetes, lung disease, kidney disease, blood disease, cancer, TB, epilepsy, asthma, mental disorders or autoimmune disease) ?

____

____

____

15. Have you experienced any other health issues? ____

____

____

16. Have you ever had a bad reaction to an anesthetic? Yes ________ No _________

Explanation ____

17. Has any family member had a reaction to an anesthetic? Yes ________ No _________

Explanation ____

18. Have you required unusually large amount of local anesthetic for medical or dental purposes? Yes ________ No _________

Explanation ____

19. Do you bleed or bruise easily or have any bleeding tendencies? Yes ________ No _________

Explanation ____

20. Have you or any family members ever had a problem with blood clots in the legs (DVT) or pulmonary embolism? Yes ________ No _________

Explanation ____

21. Have you ever required a blood transfusion? Yes ________ No _________

Explanation ____

22. Have you ever been tested for HIV? Yes ________ No _________

Explanation ____

23. Are you in a high risk category for HIV? Yes ________ No _________

Explanation ____

24. Have you ever had high blood pressure? Yes ________ No _________

Explanation ____

25. Have you ever had scarlet fever or rheumatic fever? Yes ________ No _________

Explanation ____

26. Have you ever had hepatitis? Yes ________ No _________

What type? ____

27. Do you form large scars or keloids? Yes ________ No _________

Explanation ____

28. Do any family members form large scars or keloids? Yes ________ No _________

Explanation ____

29. Do you have frequent skin infections, rashes, eczema or skin disease? Yes ________ No _________

Explanation ____

30. Have you taken steroid medications, cortisone or ACTH? Yes ________ No _________

Explanation ____

31. Do you develop shortness of breath with walking? Yes ________ No _________

Explanation ____

32. Do you experience chest pain? Yes ________ No _________

EKG Date _________________________

33. Have you ever had a period of depression or anxiety? Yes ________ No _________

Explanation ____

34. Have you ever taken medication for depression or anxiety? Yes ________ No _________

What Medication? ____

35. Are you a survivor of chemical, alcohol or sexual abuse? Yes ________ No _________
36. Is there anything else we should know about you? ____

____

Some personal questions

1. What would you most like to achieve with a cosmetic procedure? _______________________________________

____

2. How did you select Dr. Nygaard to care for you? ____

____

3. May we thank a patient or friend for referring you to our office?

____

4. Will you require information about local hotel accommodation or possible postoperative caretaker? ______________

____

The signature below indicates that the above health information is accurate and complete.

____ Date: _________________

Signature of patient or responsible guardian

1414 116th Avenue NE
Suite C
Bellevue, WA 98004
(425) 646-7472 • Fax (425) 453-1123

Consent of Disclosure

(For the usage and/or disclosure of protected health information)

I hereby give consent to Renaissance Center for Facial & Body Sculpting (Christine Nygaard, M.D.) and all health care providers furnishing care within Renaissance Center for Facial & Body Sculpting's facilities to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by contacting our office and speaking with our privacy officer at (425) 646-7472.

NAME OF PATIENT____

SIGNATURE ____

If you are signing as the patient's representative:

PRINT YOUR NAME ____

RELATIONSHIP ____