INSTRUCTIONS: Print out this two page form, answer all questions, and bring the form with you to our office. If you have any questions before then, please call us at 805-983-2455. Thank you.

Frank Meronk, Jr., M.D.
NEW PATIENT REGISTRATION

Ms Miss Mrs Mr Dr ___________________________________ Date of Birth ____________

Age ___________ Driver's License _________________________

Address _______________________________ Email (no spam)_____________________________

City __________________________________ State _________ Zip ____________

Home phone ________________________ Cell phone _________________________

Occupation _________________________ Work phone ________________________

Emergency Contact: Name _______________________ Relationship_________ Phone ___________

May we leave a message for you on your: Home phone Yes___ No___ Cell phone: Yes___ No___

Describe your reason for this visit:

Have you already consulted with other doctors regarding your eyelids? Yes___ No ___

Circle known medical problems: Heart Lung Cancer Blood Pressure Diabetes Thyroid
Skin Liver Neurological Psychiatric Kidney Immune Arthritis Eyes
Ear, Nose, Throat Easy Bleeding Frequent Cold Sores Abnormal T-Cell Count
Other (describe):

List all medications (If none, check here _____):

List medication allergies (If none, check here _____):

Do you routinely take aspirin, ibuprofen, Alleve, Vitamin E, or dietary supplements? Yes___ No___
If so, list:

List all previous eyelid/facial operations and any other plastic surgery (give date and name of doctor):

List any other operations:

Have you had Botox or fillers injected into or around your eyelids? Yes ___ No ___ If so, list:

Do you now smoke? Yes___ No___ If not now, did you used to? Yes___ No___

List diseases that run in your family:

Is there anything else about your medical history that we should know? Yes___ No___

How did you learn about Dr. Meronk's practice? Circle answer(s):

Friend   Doctor Referral   Internet   Yellow Pages   Newspaper   Other ___________

Have you ever been told by any doctor or have reason to believe that you may be overly fixated on the appearance of your eyelids, face, skin, or body or suffer from body dysmorphic disorder (BDD)?
Yes ___   No___   Explain:

Have you ever been told by any doctor or have reason to believe that you may suffer from obsessive-compulsive disorder, hypochondriasis, anxiety, depression, other psychological disorders, or are a perfectionist?   Yes ___   No ___   Explain:

• **General Financial Responsibility Agreement**

I understand and agree that I am personally responsible for all fees incurred by me for medical care provided by Dr. Frank Meronk, Jr., and his staff. Full payment is not subject to my approval of final results. I understand that cosmetic surgery is not covered by or billed to medical insurance. If payment is made by credit card, I agree not to cancel payment or request a refund after care has been delivered. No other agreements have been offered or implied.

• **Surgery Payment Terms**

Our prices for surgery are subject to periodic increases. Any price quote given will be honored for a period of sixty days, after which your costs may be higher if our regular fee schedule has changed in the interval.

All surgery fees must be paid in full at least ten full business days prior to your operation. If payment is not made by this date, the amount due will be increased by 10% or your surgery spot may be assigned to another patient.

Your surgery prepayment is fully refundable as long as you cancel or reschedule your operation at least five full business days prior to your scheduled treatment. If you cancel less than five full business days in advance for any reason, a $1,000 late cancellation charge ($2,000 between December 15 and January 5) will be deducted from your refund and will not be applied to any surgery undertaken at a future date.

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Do not sign without reading this full form: In signing below, I attest that all information provided is accurate and complete and that I understand and agree to the 'General Financial Responsibility Agreement' and 'Surgery Payment Terms' noted above.

Signature ___________________________________ **Date** ________________

(Note: If you elect to have surgery, you will be asked to fill out a more detailed Health Questionnaire)