Please complete this form before your scheduled appointment and send to info@drberger.com

DR. BERGER - REGISTRATION FORM

Date _____

First Name _____ Last Name _____ Nickname _____
Home Phone _____ Cell Phone _____ Work Phone _____
Home Street Address _____
City _____ State _____ Zip _____
Occupation / Employer _____
Work Street Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Driver's Lic. No. _____ Soc. Sec. No. _____
Marital Status : ☐single ☐married ☐widowed ☐divorced ☐separated
Emergency Contact(s) _____

Medical Information

Please list all prescription or over-the-counter medications you are currently taking, or have taken in the last 2 months (including the dose):

_____
_____
_____

Do you have any allergies? ☐NO ☐YES - If yes, please list: _____
_____

Have you taken any steroids (ex. prednisone) or any hormones (ex. birth control pills, estrogen/progesterone/testosterone) in the past year? ☐NO ☐YES

Are you taking diet pills, vitamins, herbal products, homeopathics or supplements? ☐NO ☐YES

Have you ever been diagnosed with any type of cancer or treated with chemotherapy? ☐NO ☐YES

Have you, or any family members, had any adverse reactions to anesthesia or surgery? ☐NO ☐YES

Have you or any family members experienced any bleeding or clotting problems? ☐NO ☐YES

Please list all surgeries both cosmetic and non-cosmetic:

_____
_____
_____

Have you been hospitalized for any reason other than surgery? ☐NO ☐YES - If yes, please describe:
_____
_____

Have you ever smoked? ☐NO ☐YES – If yes, do you currently smoke? ☐NO ☐YES

Do you consume alcohol? ☐NO ☐YES

Do you use “recreational” drugs or marijuana (*this information is confidential*)? ☐NO ☐YES

When was your last medical exam? _____ Who is your primary doctor? _____
Primary doctor's telephone:_____

Do any illnesses or conditions run in the family? ☐NO ☐YES - If yes, please list: _____
_____

Please check any conditions that you have had:

☐High Blood Pressure	☐Heart or Valve Conditions	☐Bleeding / Bruising Tendency
☐Anemia	☐Eye Disease or Dry Eye	☐Asthma
☐Blood Transfusions	☐Irregular / Rapid Heart Rate	☐Diabetes
☐Stomach Ulcer	☐HIV+ / AIDS	☐Kidney Disease
☐Autoimmune Condition	☐Hepatitis	☐Thyroid Condition
☐Depression	☐Weight Loss	☐Tuberculosis
☐Radiation Treatment	☐Blood Clots in your Legs	☐Scar Problems

*** For Women Only ***

Total Pregnancies: _____ Live Births _____ Last Mammogram _____ Last menstrual period _____

I verify that the information in this form is accurate and complete to the best of my knowledge.

_____ Date: _____
Patient Name (or parent, if minor) - sign in office

_____
Relationship, if signing for a minor

AUTHORIZATION FOR TAKING OF MEDICAL PHOTOGRAPHS AND/OR VIDEOS

Medical photographs and/or videos may be taken before, during or after a medical treatment, surgical procedure, or injection. Consent is required to take such images.

I hereby authorize Dr. Saul R. Berger and/or his associates or licensees to take photos and/or videos before, during and after treatments, procedures or surgeries. *These images will be used for my care, and will not be used for marketing or other purposes unless I consent to other uses in a separate consent form.*

Initials: _____

INFORMATION SHARING

We are restricted from sharing information about your care according to HIPAA regulations. If you wish to grant permission to allow our staff to discuss your care with another individual, including a spouse or family member, you must specify such individuals below:

Name / Relationship / Telephone: _____

_____

COMMUNICATION PREFERENCES

As individuals rely increasingly on email and text communications, we may provide information to you by electronic means. Information sent by these means will be non-urgent and non-critical in nature. However, such information is not encrypted and its confidentiality cannot be assured.

☐ I grant permission to send information pertaining to my medical care via email at:
Email address _____

☐ I grant permission to send information pertaining to my medical care via text at:
Mobile telephone _____

I understand that Saul R. Berger, MD, Inc. will never share my information with any third-party entities, except: i. for use with medical practitioners engaged in my care; ii. when requested to do so at your request; or iii. when required by law.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the
Medical Board of California,
(800) 633 – 2333, www.mbc.ca.gov

I understand all of the information and policies above, and consent to your policies and procedures.

Patient Name: _____ Date: _____

EXPLANATION OF FINANCIAL POLICIES

For all in-office services and treatments, as well as retail products, payment is due at the time of service. For all cosmetic surgeries, payment is due two weeks in advance of surgery. You may be responsible for other costs that are not included under services, such as special garments, materials, medications, laboratory and other tests.

To schedule surgery and reserve a date, a signed Deposit Agreement along with a non-refundable deposit will be required. This will reserve time on the schedule for Dr. Berger, anesthesia services, and the surgical facility. Should you need to change your surgical date after you have signed the Deposit Agreement, a new non-refundable deposit will be required. Any cancellations made after all fees are paid will not be refunded. Any exceptions to this policy, such as for extenuating circumstances, can only be approved by Dr. Saul Berger.

Payments can be made by credit card, cash, bank check or using Alphaeon credit (Alphaeon is accepted for surgeries only). We do not accept any personal checks for payment. We also do not accept payment from any medical insurance plans or companies, nor do not process or complete any kind of documentation related to health insurance plans or companies.

At your request, we may complete forms in your behalf that require a physician signature. Typical forms may be related to disability, time off work, family leave, gym membership suspensions, modified duty, etc. These forms require staff time to complete. Our current guidelines for completion of forms are:

1. There is a $25.00 processing fee for each form.
2. You must complete your portions of any forms prior to submission to our office.
3. Forms cannot be completed “while you wait.” They will be handled on a first-come, first-serve basis and made available to you after completion.
4. It is your responsibility to forward completed forms to the proper agency or entity.
5. Dr. Berger cannot accept forms directly from you; they must be submitted at the front desk.

I have read and fully understand my financial responsibilities regarding my treatment.

Patient Name: _____ Date:_____