Dr. Brennan's
COSMETIC CENTER

400 Newport Center Drive, Ste 100 | Newport Beach, CA 92660
Office: (949) 644-1641 | Fax: (949) 644 - 2518

PLEASE ANSWER ALL QUESTIONS

NAME ____
last first middle initial

PATIENT'S SOCIAL SECURITY # ______________________ AGE ________ BIRTHDATE ______________

HOME ADDRESS ____
street apt number

____
city state zip code

HOME (______) ____________________ CELL (______) ____________________ WORK (______) ____________________

BEST CONTACT NUMBER(Please circle one) HOME / CELL / WORK

E-MAIL ______________________________ CAN WE EMAIL YOU ? YES NO

EMPLOYER ______________________________ OCCUPATION ______________________

NAME OF SPOUSE / PARENT / RESPONSIBLE PARTY(if other than patient) ______________________

HOME (______) ____________________ CELL (______) ____________________ WORK (______) ____________________

EMERGENCY CONTACT ____

RELATIONSHIP ______________________________ PHONE(______) ____________________

INSURANCE INFORMATION:

Insurance Company Name:	❑ HMO ❑ PPO ❑ Other
Policy Holder's Full Name	Co--Pay: $
Policy Number:	Phone Number:
Address:	

REFERRED BY(Please circle one) MD / FRIEND / FAMILY / OTHER ______________________

HAVE YOU CONSULTED WITH ANOTHER PHYSICIAN? IF SO WHO ______________________

PRIMARY PHYSICIAN ____

REASON FOR CONSULTATION (LIST ALL) ______________________

SELF PAY

I do not have health insurance and will be responsible for services rendered here at Dr. George Brennan's Office. I agree to pay the full and entire amount for services rendered.

______________________________ ______________

PATIENT/GUARANTOR SIGNATURE DATE

Dr. Brennan's
COSMETIC CENTER

MEDICAL HISTORY
Surgical

NAME ______________________________ DATE ______________

DATE OF YOUR LAST PHYSICAL EXAMINATION ______________________ WEIGHT __________ HEIGHT __________

SURGERY (OPERATIONS AND COSMETIC SURGERY)

TYPE DATE COMPLICATIONS OR DIFFICULTIES

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

MEDICAL PROBLEMS OR CONDTIONS NOW UNDER TREATMENT BY A PHYSICIAN

EXPLAIN ______________________________

ADMISSIONS TO HOPSITAL

REASON DATE COMPLICATIONS OR DIFFICULTIES

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU TAKE NOW

TYPE DOSAGE/AMOUNT IF KNOWN TAKE HOW OFTEN

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

CONSUPTION OF THE FOLLOWING

ASPIRIN ____________ AMOUNT DAILY ____________ AMOUNT WEEKLY ____________

ALCOHOL ____________ AMOUNT DAILY ____________ AMOUNT WEEKLY ____________

TOBACCO ____________ AMOUNT DAILY ____________ AMOUNT WEEKLY ____________

OTHERS ____________ AMOUNT DAILY ____________ AMOUNT WEEKLY ____________

BLEEDING PROBLEMS

DO YOU BRUISE OR BLEED EASILY? YES NO (WITH CUTS / TOOTH EXTRACTIONS / PREGNANCY / SURGERY)

EXPLAIN ______________________________

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA

EXPLAIN ______________________________

HAVE YOU EVER HAD A BLOOD TRANSFUSION?

ARE YOU PREGNANT

YES NO

HAVE YOU EVER HAD OR BEEN EXPOSED TO (ALL THAT APPLY)

- O Intravenous Drugs
- O TB
- O HIV/AIDS
- O Infectious Diseases
- O Hepatitis
- O Liver Transplant

IF YES TO ANY EXPLAIN ______________________________

HISTORY OF EPILEPSY OR MENTAL CONDITIONS

EXPLAIN____

____

FAMILY HISTORY

ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

MOTHER______________________________

____

FATHER ______________________________

____

SISTER ______________________________

____

BROTHER ______________________________

____

OTHER RELATIVE:

REVIEW OF SYSTEMS

ANY MEDICAL PROBLEMS WITH ANY OF THE FOLLOWING:

O Head	O Eyes	O Ears
O Thyroid	O Lungs	O Heart
O Blood Pressure / Vessels	O Digestive Systems	O Liver
O Muscles/Bones	O Reproductive Organs	O Kidney's - Bladder
O Liver	O Unsightly Scars	O Heart
O Blood Pressure / Vessels	O Digestive Systems	O Immune System Disease

PLEASE EXPLAIN ____

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST ALL.

____

____

____

____ ______________________________

PATIENT SIGNATURE DATE

Areas of Interest Questionnaire

Please check any of the following that bother you about your skin face or body.

- o Wrinkles
- o Brown Spots
- o Acne
- o Dry Skin
- o Frown Lines
- o Aging Hands
- o Vaginal
- o Eyelids
- o Pore Size
- o Redness
- o Scars
- o Oily Skin
- o Sagging Skin
- o Spider Veins
- o Vaginal Laxity
- o Nose
- o Texture
- o Rosacea
- o Unwanted Hair
- o Thin lips
- o Aging Neck
- o Facial Veins
- o Incontinence
- o Other
- o Drooping Brow
- o Length/Fullness of Lashes
- o Thinning Hair
- o Aging Chest
- o Loss Of Volume In Cheeks
- o Breast
- o Pelvic Pain

OTHER COMMENTS:

____

____

____

Photography Morphing : At some time within your visits to our office you may be given a morphed photo to portray the expected result. These photos are a
simulation *only* and in no way a guaranteed result.

Signature	Date / /

Patient Photographic Release : In connection with the medical services which I am receiving from H. George Brennan, M.D, I consent that photographs may be taken of me or parts of my body under the following conditions: 1. The photographs may be taken only with the consent of my surgeon. 2. The photographs shall be taken by my physician or by a competent photographer approved by my physician. 3. These photographs shall be used for medical records only unless, in the judgment of my physician, medical research, education or science will benefit by their use. In the event my photos are used I understand that I will not be identified by name without prior permission. I release and discharge my physician and all parties acting under his license and authority from any and all claims or actions that I have or may have relating to such use and publication and all right, if any, that I may have in such photographs and details regarding medical services rendered to me, including any claim payments in connection with such use or publication.

Signature	Date / /

Insurance Assignment & Release: I hereby authorize the doctor whose name appears above to furnish information to insurance carriers concerning my illness and treatments and irrevocably assign to the doctor all payment for medical services rendered to myself or my dependents. I realize that all medical and surgical charges incurred are my financial responsibility. Should the account become delinquent the entire amount shall be due and payable by me. I understand that I am responsible for any amount not covered by insurance. I understand I am responsible for payment in full at the time the service is rendered. A photocopy of this authorization is as valid as the original.

Signature	Date / /

PHYSICIAN-PATIENT ABRITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** I is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submissions to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract, or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners associates, associates, corporations, partnerships employees agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both other and the mother's expected child or children.

Filing by Physician of any action in any curt by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, ay fee dispute whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages south, and the names, addresses and telephone numbers of patient, and (if applicable) his/her attorney, The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge to presides over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure && 1280-1295 and the Federal Arbitration Act (9 U.S.C. && 1-4) The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the agreement enforced in accordance with California law.
I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________
Physician's or Duly Authorized Representative Signature (Date)

H. GEORGE BRENNAN, M.D.
400 NEWPORT CENTER DR., STE 100
By: NEWPORT BEACH, CA 92660
Print or Stamp Name of Physician, Medical Group or Association Name

By: ______________________________
Signature of Translator (if applicable) (Date)

____
Print Name of Translator

By: ______________________________
Patient's Signature (Date)

____
Print Patient's Name

By: ______________________________
Patient's Representative's Signature (if applicable) (Date)

____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Orignal is to be filed in Patient's medical records.