Zen Medical Care, PLLC
Janis L. Enzenbacher, MD

Facial Esthetics Intake Form

Date: _____

Name: _____ DOB: ___/___/____ Age: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____
Would you like to be added to our email list for information and promotions? ☐ Yes ☐ No
How did you hear about us? / Who were you referred by?

_____

Pharmacy - Name, Address and Phone:

_____

Emergency Contact:
Name: _____ Phone: _____
Relationship: _____

Medical & Cosmetic History

Do you have any allergies? ☐ Yes ☐ No
If yes, list:

_____
_____

Are you currently taking any prescription or OTC medication? ☐ Yes ☐ No
(Including vitamins and supplements)
If yes, list:

_____
_____

Have you had any cosmetic reconstructive or plastic surgery? ☐ Yes ☐ No
If yes, list:

_____
_____

Do you have chronic medical conditions? ☐ Yes ☐ No
If yes, list:

_____
_____

Are you pregnant or nursing?	☐ Yes ☐ No	Do you have any skin conditions?	☐ Yes ☐ No
Do you have epilepsy or other neurological disorders?	☐ Yes ☐ No	Do you have an auto immune disorder?	☐ Yes ☐ No
Do you have diabetes?	☐ Yes ☐ No	Do you have Lupus?	☐ Yes ☐ No
Do you have any cardiovascular conditions?	☐ Yes ☐ No	Do you have Herpes or cold sores? (active or inactive)	☐ Yes ☐ No
Do you have high blood pressure?	☐ Yes ☐ No	Do you have amyotrophic lateral sclerosis?	☐ Yes ☐ No

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Have you previously had any facial esthetics treatments? (i.e. Botox, Dermal Filler, Smoothing and/or lifting threads) Please List:

Type of Treatment	Location (i.e. Eleven lines, Lips, Crows Feet, Neck, etc)	Dates of Procedures

Please describe the facial esthetic treatment(s) you are requesting for your first appointment and what results you are hoping to achieve. Please be specific as to which areas of the face and method. (i.e., Botox, Filler, Solid Filler (smoothing/lifting threads) etc.)

_____

_____

_____

_____

Which facial esthetic treatment (s) if any are you interested in receiving in the future?

_____

_____

_____

_____

I have been given, read and understand the pre & post instructions for the facial esthetics treatment I am receiving.

Print Name: _____

Signature: _____ Date: _____

Janis L. Enzenbacher, MD
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/ or received a copy of the Janis L. Enzenbacher, MD: Patient Notice of Privacy Practices/ HIPAA effective January 1, 2015

Date: _____

Print Name: _____

Patient Signature: _____
(or guardian, if applicable)

Please be advised that I _____ do not want give any authority or consent to give out any information of my medical history or diagnosis with any party. Under no circumstances should my medical history be given to anyone.
Date: _____

Patient Signature: _____

PRACTICE POLICY & PAYMENT AGREEMENT:

Payment for all services including; ALL CONSULTS, and recommendations for treatment must be paid in full at the time of the visit for services rendered.

Payment can be made with credit/debit card, cash or check. **Payments made with credit/debit card will incur a 3% processing fee.** We charge a processing fee for all returned checks. Outstanding balances beyond 30 days will be charged a monthly interest fee of 1.5%.

The above services are not typically covered by medical health insurance companies including Medicare. Upon request, we can provide a receipt for services rendered. All services above are non-refundable.

I, _____, understand that I am responsible for the balance of my account, for any and all professional services rendered on my behalf. I accept full responsibility for the payment of these services.

Cancellation Policy

Cancellations for all appointments must be made within 24 hours of the scheduled appointment. This can be done by leaving a message at 914-325-1664 or email at janiszen@drgyn.us.If the appointment is not cancelled within this time period then you will be charged 75% of the cost of service. Exceptions will be made with the discretion of practitioner.

Print Name _____

Signature _____ Date _____