RENU
AESTHETICS BY DR. SCHOENFELD

ADULT PATIENT DEMOGRAPHICS

Last Name _____ First Name _____MI_____

Address _____City _____ST____ Zip_____

Cell _____ Home _____Work _____

E-Mail _____ ___ Male ___ Female

May we send text appointment reminders? **Y N** E-Mail? **Y N**

Date of Birth: _____/_____/_____ □ Single □ Married □ Divorced □ Widowed □ Partner

Employer _____Occupation _____

Emergency Contact Name _____Phone ( ) _____

How did you hear about our practice? _____

Patient Agreement

I, the undersigned, am aware that I am financially responsible for all services rendered to me by Feldman ENT and Renu Med Spa.

I am aware that I am personally responsible for all co-payments, deductibles, and non-covered services as dictated by my insurance coverage.

I, the undersigned, hereby authorize Feldman ENT and Renu Med Spa to apply for benefits for covered services rendered by the Practice and request that the payments from my insurance carrier are paid directly to the practice.

I certify that the information I have provided with regard to my identity and insurance coverage is correct, and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier(s). I permit a copy of this authorization to be used in place of the original.

I, the undersigned, am aware that I will be charged a No Show fee of $100.00 for any appointment I cancel without a twenty-four (24) hour notice.

Signature: _____ Date: _____/_____/_____