JEANNIE CHUNG
PLASTIC SURGERY • SKIN REJUVENATION

Welcome to our practice, we look forward to meeting you at your consultation appointment.

In order to ensure we stay on time, we ask that you kindly fill out the enclosed registration documents and bring them with you to your appointment completed.

Dr. Chung charges a $175 consultation fee. If you choose to have a treatment on the day of your consultation or make a deposit towards a future surgical procedure, the consultation fee will be applied.

Our practice accepts the following forms of payment: MasterCard, Visa, Discover, Personal Check, Cash or Care Credit*. Sorry, we are unable to accept American Express.

Please contact the office at least 48 hours before your scheduled appointment if you need to cancel in order to avoid “no show” fees.

We look forward to meeting you.

Sincerely,

Julie Finn
Practice Manager

40 Walnut Street, Suite 202
Wellesley, MA 02481
(781) 235-3223 | (781) 235-2210 fax
info@drjeanniechung.com | www.drjeanniechung.com

PATIENT REGISTRATION (please print)

Patient
Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Social Security # _____ Martial Status_____

Street Address _____ City _____

State _____ Zip _____ EMAIL _____

Phone (H) _____ (C) _____ (W) _____

May we contact you at □ Home Phone □ Cell □ Work
□ Home Address □ Email

Occupation_____ Employer _____

PCP: _____ Address: _____

Pharmacy: _____ Address: _____

How did you hear about us: _____

Emergency Contact Name _____ Phone Number _____

If you are NOT a self-pay patient, please complete the remainder of the form

If Patient Is Under The Age of 18, We Require Responsible Party DOB & SSN

Primary Insurance _____

Insurance ID# _____ Group # _____

Street Address _____ City _____ State _____ Zip _____

Name Of Person Who Carries Insurance _____ SSN _____ DOB _____

Patient Relationship To Insured _____

Insured Employer _____ City/State/Zip _____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS INCLUDING MEDICARE PRIVATE INSURANCE AND OTHER PLANS TO JEANNIE H. CHUNG, MD, P.C. I GIVE AUTHORIZATION TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY THAT IT MAY NEED.

Patient's Signature (If 18 years or older) _____ Date _____

Parent/Guardian's Signature (If under 18 years) _____ Date _____

Jeannie Chung MD PC
40 Walnut Street # 202
Wellesley, MA 02481
781-235-3223

Medical History

Date: _____

Name: _____ DOB: _____

Allergies to Medications & or Foods, please detail reaction:

_____
_____
_____

Medications/Vitamins of Homeopathic Regime, Topical Regime: (very important to note if take any blood thinner/aspirin like medications, if so dose)

_____
_____
_____
_____

Medical History: (very important to note if history of skin cancer, heart condition/pacemaker or bleeding disorders)

_____
_____
_____
_____
_____

Family History: (very important to note if history of family skin cancer, particularly Melanoma)

_____
_____
_____

Surgical History:

_____
_____
_____

Social History:

Smoker: _____, if yes how many cigarette's/packs per day? Occupation/Sun Exposure:

_____
_____

Other:_____
_____