



DAVID W. KIM MD

FACIAL PLASTIC SURGERY

Patient information as of _____ (Today's Date)

Name: _____ Address: _____

City: _____ State: _____ ZIP: _____ Home phone: _____

Mobile: _____ E-mail address: _____ DOB: _____

Reason for visit: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Mobile: _____

How you heard of us (please check)

- | | | |
|---|--|--|
| <input type="checkbox"/> Yelp.com | <input type="checkbox"/> drkimfacialplastics.com | <input type="checkbox"/> Realself.com |
| <input type="checkbox"/> Other site _____ | <input type="checkbox"/> Google.com | <input type="checkbox"/> Event/Seminar |
| <input type="checkbox"/> Local Business | <input type="checkbox"/> New Beauty Magazine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Doctor _____ | <input type="checkbox"/> Friend _____ | |

List all prescription medications/supplements you are currently taking.

NONE _____

List allergies or side effects to any drug medications.

NONE _____

List any other allergies, such as to foods, pollen, eggs, iodine, shellfish, latex, etc.

NONE _____

FEMALES: Are you currently pregnant or breastfeeding?

Yes No

Are you planning on becoming pregnant?

Yes No

Dermatologic History (please check)

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Cold Sores/Herpes Simplex | <input type="checkbox"/> Keloids/hypertrophic scars | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Shingles | <input type="checkbox"/> Skin infection | <input type="checkbox"/> Accutane use for acne |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Vitiligo | <input type="checkbox"/> Dermal filler |
| <input type="checkbox"/> Melasma | <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Laser resurfacing | <input type="checkbox"/> Botox/Dysport |
| <input type="checkbox"/> Lupus | | | |

Past Medical History (please check)

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Fainting /Syncope | <input type="checkbox"/> Neuromuscular disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Blood/bleeding disorder | <input type="checkbox"/> Pacemaker/defibrillator | <input type="checkbox"/> Psychiatric/mental illness |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Migraine/headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty with speech or swallowing | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Salivary gland problems | <input type="checkbox"/> Hepatitis A/B/C |
| <input type="checkbox"/> Abnormal immune system | <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | | |

I attest that my answers are true and correct. I will inform Dr. David W. Kim, MD of any changes in my medical condition, including new medications and supplements, during the course of my treatment.

Patient signature: _____ Date: _____

Please check the box(es) that best describe(s) your skin.

- | | |
|---|---|
| <input type="checkbox"/> Always burns, never tans | <input type="checkbox"/> Rarely burns, tans well |
| <input type="checkbox"/> Usually burns, then tans | <input type="checkbox"/> Very rarely burns, tans well, brown skin |
| <input type="checkbox"/> May burn, tans well | <input type="checkbox"/> Very rarely burns, tans well, very dark skin |

Do you use chemical or "sunless" self-tanning lotions? Yes No

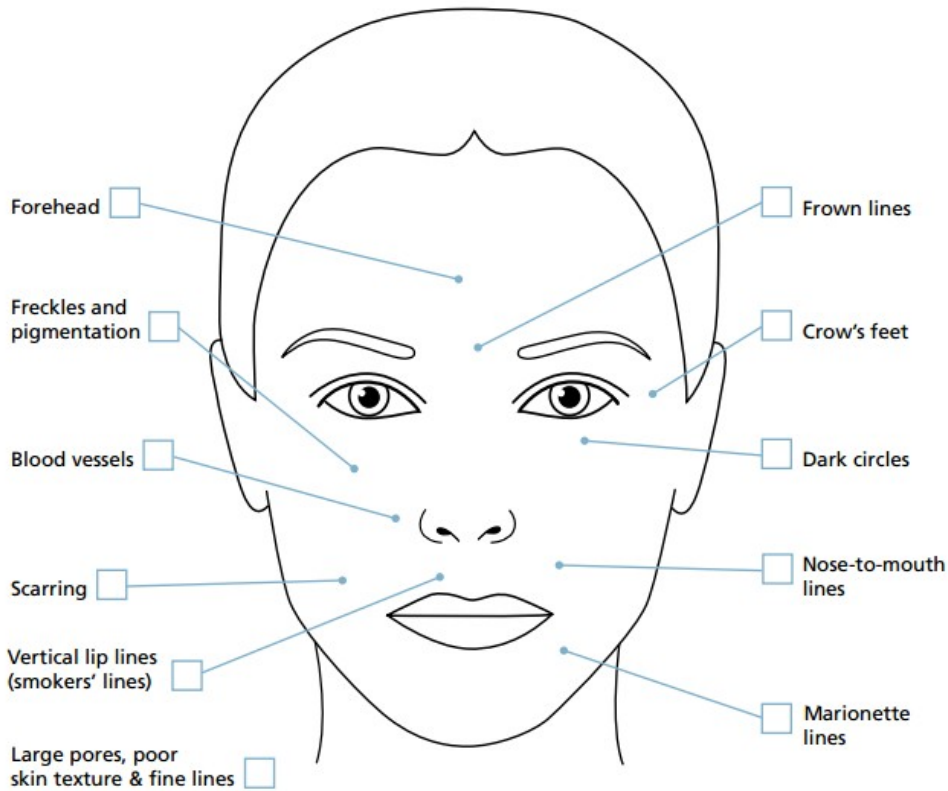
Do you sunbathe or use tanning beds? Yes No

Do you use sunscreen? Never Sometimes Always What SPF? _____

What services or concerns would you like to learn about? Please check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Skin care advice | <input type="checkbox"/> Brown spots/age spots | <input type="checkbox"/> Facial veins |
| <input type="checkbox"/> Skin care products | <input type="checkbox"/> Drooping brow | <input type="checkbox"/> Facial redness |
| <input type="checkbox"/> Injectable Treatments - Fillers | <input type="checkbox"/> Drooping eyelids | <input type="checkbox"/> Neck wrinkles |
| <input type="checkbox"/> Acne scars | <input type="checkbox"/> Nose size or shape | <input type="checkbox"/> Facial Contouring |
| <input type="checkbox"/> Facial fine lines/wrinkles | <input type="checkbox"/> Chemical peel | <input type="checkbox"/> Mole removal |
| <input type="checkbox"/> Thin lips | <input type="checkbox"/> Length/Fullness of Eyelashes | <input type="checkbox"/> Scar revision |

With respect to signs of aging, please highlight those areas of the face that bother or trouble you. In the box provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome).



Is there an upcoming event/date you are working with? _____

Have you had any previous non-surgical cosmetic treatments? (Botox, Fillers, Lasers, Peels etc.). If yes, what treatments and when?

Have you had any previous cosmetic surgeries? If yes, what procedures and when?

Cancellation Policy

We will ask you to secure your appointment time with a credit card. Your card is not charged, but in the event you do not show for your appointment, a late notice fee will apply. If you need to cancel or reschedule your appointment, we ask that you please provide us with at least 2 business days (48 hours) notice to avoid a late notice fee.

Signature: _____ Date: _____

Authorization for Release and Use of Patient Photograph(s)

I consent to the taking of photographs for my medical record by David W. Kim, M.D. or his staff. I further authorize use of photographs for patient education in the office. I understand that I will not be identified by name in any of these photographs.

I also permit Dr. Kim to use these photographs for the purposes listed below unless crossed out to indicate my preference not to provide permission for that use.

- Use on Dr. Kim's website
- Use in promotional materials for Dr. Kim's practice

If I prefer that these photos be used only on the condition that identifiable features are obscured (through close up of the site such as the nose or a photo with my eyes blacked out) I will indicate this to Dr. Kim's staff.

Signature: _____ Date: _____

HIPPA

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, at Dr David W. Kim, MD.

I waive any right to compensation for the above uses, and I agree to hold Dr. Kim and his professional corporation, agents, and employees, harmless from and against any claim for injury or compensation resulting from the activities authorized in this agreement.

Signature: _____ Date: _____