



Patient Information as of \_\_\_\_\_ (enter today's date)

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

SS # \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ WORK PHONE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_  Please check if we should not use email to contact you

REASON FOR VISIT: \_\_\_\_\_

Please tell us how you heard of us, check all that apply.

INTERNET (please specify)  dwkimmd.com  realself.com  newbeauty.com  google.com

yelp.com  citysearch.com  aafprs.org  other website: \_\_\_\_\_

Magazine  TV  Newsletter  Event / Seminar  Local Business \_\_\_\_\_

UCSF  SFOMG  Union Square Hearing  Referring Doctor: \_\_\_\_\_

Friend / Relative: \_\_\_\_\_  Other : \_\_\_\_\_

If you were referred by a specific person, may we thank them?  Yes  No Name: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ OTHER \_\_\_\_\_

**Insurance IF APPLICABLE: (cosmetic consultations / procedures cannot be billed to insurance)**

Primary Health Insurance Company: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Secondary Health Insurance Company: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. David Kim to bill my insurance company ONLY for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. David Kim and myself.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



PATIENT NAME:

DATE OF BIRTH:

What is the primary reason for your visit today?

What additional services would you like to learn about? Please check all that apply:

<input type="checkbox"/> Eyelid Lift	<input type="checkbox"/> Skin Care Advice	<input type="checkbox"/> Neck wrinkles
<input type="checkbox"/> Forehead / Browlift	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Wrinkle Fillers (Injections)
<input type="checkbox"/> Facial Liposuction (Jowls)	<input type="checkbox"/> Brown spots/age spots	<input type="checkbox"/> Botox
<input type="checkbox"/> Facelift / Necklift	<input type="checkbox"/> Drooping brow	<input type="checkbox"/> Hand Rejuvenation
<input type="checkbox"/> Rhinoplasty (Nose Reshaping)	<input type="checkbox"/> Drooping eyelids	<input type="checkbox"/> Lip Enhancement
<input type="checkbox"/> Otoplasty (Ear Pinning)	<input type="checkbox"/> Facial fullness/drooping	<input type="checkbox"/> Facial Contouring
<input type="checkbox"/> Laser Resurfacing (FX)	<input type="checkbox"/> Mole removal	<input type="checkbox"/> Hair Removal
<input type="checkbox"/> Microdermabrasion	<input type="checkbox"/> Scar revision	<input type="checkbox"/> Anti-Aging Skin Care Products
<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Facial veins	<input type="checkbox"/> Length/Fullness of Eyelashes

Have you had any previous treatments? (Botox, Fillers, Laser, etc) Yes  No

If yes, how recent and were you happy with the results?

Have you had previous cosmetic surgeries? Yes  No

If yes, what procedure(s) and when? \_\_\_\_\_

If considering surgery, how far in the future would you like to have your surgery? (circle one)  N/A

2 weeks

4 – 6 weeks

6 months

1 year

Is there an upcoming occasion or date you are working with? No  Yes  \_\_\_\_\_

Is there a specific budget that you would like to stay within? No  Yes  \$ \_\_\_\_\_

Would you like to discuss financing options? No  Yes

*Cancellation Policy*

We will ask you to secure your appointment time with a credit card. Your card is not charges, 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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

List all prescription medications you are currently taking.  NONE

List all NON-prescription medications (such as aspirin, Advil, Aleve, Motrin, Vitamin A, E, Herbs supplements and Ibuprofen) you are currently taking.  NONE

List allergies or side effects to any drug medications.  NO KNOWN ALLERGIES

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

Have you had (please circle) Hearing Test, Allergy Testing, CT Sinus, MRI Brain / Neck?

Have you or your family had bleeding or Anesthesia Problems? (Please circle) Yes / No

**PERSONAL MEDICAL HISTORY (please check)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Migraine/ headaches     | <input type="checkbox"/> Thyroid Disease  |
| <input type="checkbox"/> Depression/ Mania        | <input type="checkbox"/> Eczema/ Psoriasis       | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Asthma / Lung disease    | <input type="checkbox"/> Salivary Gland Problems | <input type="checkbox"/> Eye Disease  |
| <input type="checkbox"/> Hearing Loss             | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Seizure/ Stroke  |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Abnormal Immune system  | <input type="checkbox"/> Yeast/ Fungal Infection                                |
| <input type="checkbox"/> Bleeding                 | <input type="checkbox"/> Nose Bleeding           | <input type="checkbox"/> Swallowing problems                                    |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Ear/ Sinus Infection    | <input type="checkbox"/> Hepatitis  |
| <input type="checkbox"/> Weight Loss              | <input type="checkbox"/> Snoring/ Sleep Problems | <input type="checkbox"/> Heart Burn/ GI <input type="checkbox"/> Disease        |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Hoarseness              | <input type="checkbox"/> Sexually Transmitted <input type="checkbox"/> Diseases |
| <input type="checkbox"/> Arthritis/ Joint problem | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> AIDS   |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Autoimmune Disease      | Other : _____   |

**FAMILY HISTORY (please check)**

- |                                       |   |                                   |
|---------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Autoimmune Disease | Other: _____                      |

**SOCIAL HISTORY**

Cigarettes (#/day/# of /yrs) \_\_\_\_\_ If you have quit, what was the date? \_\_\_\_\_  
 Second hand smoke? Yes / No \_\_\_\_\_ Recreational drug? Yes / No \_\_\_\_\_  
 Alcohol (drinks/ week) \_\_\_\_\_ Coffee/ Tea (cups/day) \_\_\_\_\_

**HOSPITAL ADMISSIONS/ SURGERIES (Indicate the year and the reason, omit normal pregnancies)**

- No Surgery
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_

**PREGNANCY**

Are you pregnant, OR trying to get pregnant? (please circle) Yes / No

## AUTHORIZATION FOR RELEASE AND USE OF PATIENT PHOTOGRAPH(S)

Name \_\_\_\_\_

Address \_\_\_\_\_  
(street address, city, state and zip code)

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

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.

- Use in scientific publications in the medical literature
- Use in non-scientific publications in the non-medical literature
- Use in Dr. Kim's website
- Use in promotional material for Dr. Kim's practice

Conditional alterations for photos:

\_\_\_\_\_  
\_\_\_\_\_

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, from Dr. Kim.

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 \_\_\_\_\_

**PARENTS, GUARDIANS OR CONSERVATORS OF MINOR PATIENTS MUST ALSO COMPLETE THE SECTION THAT FOLLOWS:**

I have read the above Authorization and Release. I am the parent, guardian, or conservator of \_\_\_\_\_, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

Signature \_\_\_\_\_ Date \_\_\_\_\_