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)

- ❑ Yelp.com
- ❑ Other site_____
- ❑ Local Business
- ❑ Doctor _____
- ❑ drkimfacialplastics.com
- ❑ Google.com
- ❑ New Beauty Magazine
- ❑ Friend_____
- ❑ Realself.com
- ❑ Event/Seminar
- ❑ Other_____

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)

- ❑ Rosacea
- ❑ Psoriasis
- ❑ Acne
- ❑ Melasma
- ❑ Lupus
- ❑ Cold Sores/Herpes Simplex
- ❑ Shingles
- ❑ Skin Cancer
- ❑ Chemical Peel
- ❑ Keloids/hypertrophic scars
- ❑ Skin infection
- ❑ Vitiligo
- ❑ Laser resurfacing
- ❑ Scleroderma
- ❑ Accutane use for acne
- ❑ Dermal filler
- ❑ Botox/Dysport

Past Medical History (please check)

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

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.

- ❑ Always burns, never tans
- ❑ Usually burns, then tans
- ❑ May burn, tans well
- ❑ Rarely burns, tans well
- ❑ Very rarely burns, tans well, brown skin
- ❑ Very rarely burns, tans well, very dark skin

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

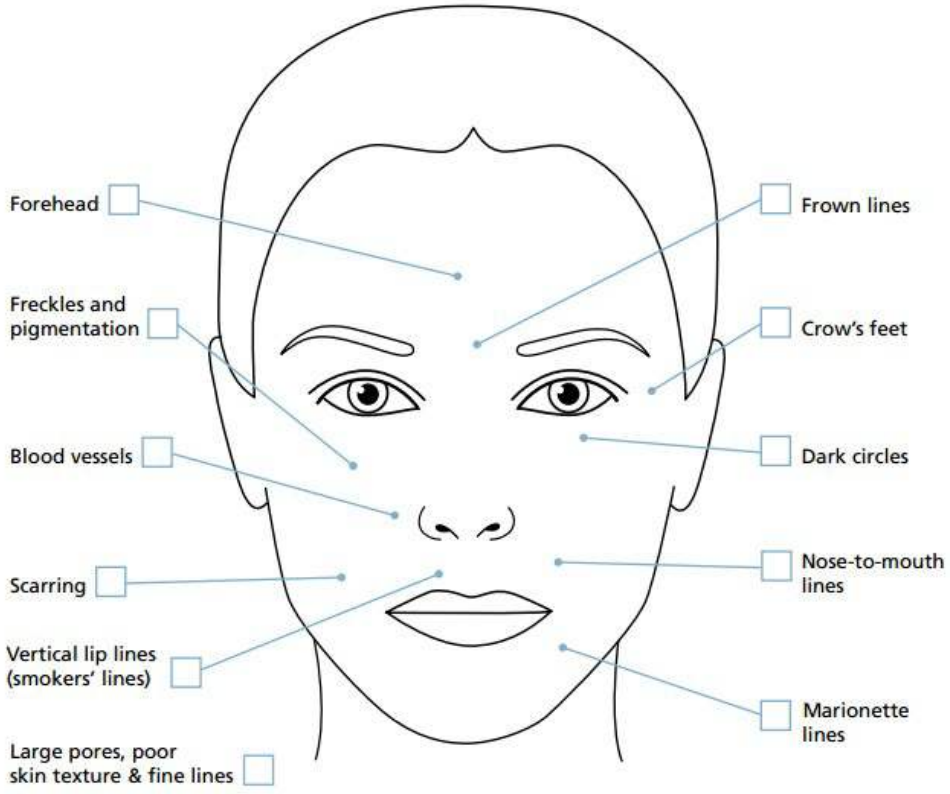
Do you sunbathe or use tanning beds? Yes No

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

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

- ❑ Skin care advice
- ❑ Skin care products
- ❑ Injectable Treatments - Fillers
- ❑ Acne scars
- ❑ Facial fine lines/wrinkles
- ❑ Thin lips
- ❑ Brown spots/age spots
- ❑ Drooping brow
- ❑ Drooping eyelids
- ❑ Nose size or shape
- ❑ Chemical peel
- ❑ Length/Fullness of Eyelashes
- ❑ Facial veins
- ❑ Facial redness
- ❑ Neck wrinkles
- ❑ Facial Contouring
- ❑ Mole removal
- ❑ 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 by 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: _____