DAVID W KIM MD
FACIAL PLASTIC SURGERY

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:** _____

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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:

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

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

## FAMILY HISTORY *(please check)*

☐ Diabetes
☐ Hearing Loss
☐ Cancer
☐ Autoimmune Disease
☐ Bleeding
Other:_____

## SOCIAL HISTORY

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