PATIENT INFORMATION RECORD

Seung K. Kim, M.D. welcomes you as a patient.

DATE	HOW DID YOU HEAR ABOUT US? :	REASON FOR VISIT TODAY? :

PATIENT AND FAMILY INFORMATION

LAST NAME FIRST MIDDLE	AGE	DATE OF BIRTH	SEX
SPOUSE (optional)	AGE	DATE OF BIRTH	SEX

EMAIL ADDRESS: IS IT OK FOR US TO SEND YOU EMAILS REGARDING SPECIALS AND EVENTS? **PLEASE CIRCLE ONE: YES NO**

ADDRESS : NUMBER AND STREET CITY STATE ZIP

BEST NUMBER AND TIME TO CALL H C W Time:	HOME PHONE	CELL PHONE	WORK PHONE
MARITAL STATUS M S D W	EMERGENCY CONTACT NAME, RELATIONSHIP & TELEPHONE NUMBER		

WHICH OF THE FOLLOWING WOULD YOU LIKE TO LEARN MORE ABOUT? (please check all that apply)

☐FACE WRINKLES/SAGGING ☐ASIAN DOUBLE EYELID ☐NOSE SHAPE/SIZE

☐EYES: HOODED/DROOPING ☐BREAST SHAPE/SIZE ☐CHIN IMPLANT/ WEAK CHIN

☐NECK WRINKLES/SAGGING ☐MOMMY MAKEOVER ☐BLOTCHY SKIN/LARGE PORES

☐ABDOMINAL AREA ☐LIPOSUCTION ☐LASER HAIR REMOVAL

☐DROOPING BROW ☐FACIAL REDNESS/BROWN SPOTS ☐LENGTH/FULLNESS OF LASHES

☐THIN LIPS/DOWNTURNED MOUTH ☐MEDICAL FACIALS/CHEMICAL PEELS

☐ CROWS' FEET/FROWN LINES/FOREHEAD WRINKLES/NASO-LABIAL FOLDS

PREVIOUS PROCEDURES (please give date of last procedure)

BOTOX_____ RESTYLANE _____ JUVEDERM_____

IPL/LASER_____ RADIESSE_____ OTHER_____

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

GENERAL HEALTH (please circle one): GOOD FAIR POOR

IF NOT GOOD, PLEASE EXPLAIN_____

SERIOUS ILLNESS (please list):_____

HEIGHT_____ WEIGHT_____ WHEN DID YOU LAST HAVE: EKG?_____ CHEST XRAY?_____

NAME OF FAMILY DOCTOR_____ ADDRESS_____

MEDICAL INSURANCE (*we require a copy of insurance info)

PRIMARY INSURANCE CARRIER _____ TELEPHONE _____ GRP NUMBER _____

ID NUMBER _____ PATIENT RELATIONSHIP TO INSURED PARTY: □ SELF □ SPOUSE □ CHILD □ OTHER _____

PREVIOUS SURGERIES (please give dates)

OPERATION_____ DATE_____

OPERATION_____ DATE_____

HAVE YOU EVER HAD ANY COMPLICATIONS FROM ANY SURGERIES? NO_____YES_____

IF YES, PLEASE EXPLAIN_____

HAVE YOU EVER HAD:

☐BLEEDING DISORDER	☐MENTAL ILLNESS	☐AIDS OR ARC
☐HIGH BLOOD PRESSURE	☐HEART DISEASE	☐EPILEPSY
☐LUNG DISEASE	☐HEPATITIS	☐CANCER

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO_____ IF YES, WHICH ONE(S) _____

WHAT IS YOUR APPROXIMATE DAILY INTAKE OF THE FOLLOWING?

TOBACCO_____ALCOHOL_____COFFEE/TEA_____SOCIAL DRUGS_____

PLEASE LIST ALL THE MEDICATION YOU ARE TAKING (INCLUDING ALL BLOOD THINNERS, ASPIRIN, BUFFERIN, BIRTH CONTROL PILLS, WATER PILLS, BLOOD PRESSURE PILLS, TRANQUILIZERS, HORMONES, ETC.)

CANCELLATION POLICY

Cancellations & No Shows

Please contact our office via email or phone AT LEAST 24 hours prior to your scheduled appointment date & time to avoid any cancellation fees.*

Patients who schedule an appointment and cancel within 24 hours of their first appointment will be billed a $75 cancellation fee.

I understand the cancellation policy and agree to its terms as well as to be charged the amount indicated via debit/credit card if I fail to follow the cancellation policy of Dr. Seung K. Kim, MD Plastic Surgery.

_____
Patient/Card Holder's Printed Name

_____ _____
Patient/Card Holder's Signature Date

We reserve the right to refuse appointments to any patients who has demonstrated disregard of our cancellation policy.

Notice of HIPAA Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for health care related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-health related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for health care operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, health care operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information. *
- You have the right to request in writing to amend, correct, or delete any recorded health information in our possession. *
- You have the right to request in writing to restrict some of the uses and disclosures of your health information. *
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office. *
- Conditions and limitations may apply; obtain additional from front desk.

Print Name_____Date_____

Patient Signature_____