



**Patient Demographic**

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

**Patient's Name**

\_\_\_\_\_

First

Middle

Last

Address \_\_\_\_\_

Street & Apt #

City

State

Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_

Contact Restrictions: \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Gender \_\_\_\_\_ Female

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

**Patient's Employer**

\_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_

Street & Suite #

City

State

Zip

**How did you hear about Dr. Kim?**

(Mark all that apply)

- Living Magazine
- Newsletter
- Seminar
- Salon
- Internet Search
- Friend/Relative: \_\_\_\_\_
- Doctor: \_\_\_\_\_
- Other: \_\_\_\_\_

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

**Emergency Contact**

(Not in your household)

\_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

**Areas of Interest:** (mark all that apply)

**Facial Procedures**

- Brow or Forehead Lift
- Earlobe Repair
- Eyelid Surgery
- Facial Liposuction (Neck, Jowls)
- Face or Neck Lift
- Otoplasty (Ear Pinning)
- Rhinoplasty (Nose Reshaping)

**Breast Procedures**

- Breast Augmentation
- Breast Reduction/Lift
- Breast Reconstruction

**Body Procedures**

- Abdominoplasty (Tummy Tuck)
- Liposuction (Thighs, Abdomen, Etc.)
- Thigh or Buttock Lift

**Other Services**

- Botox
- Skin Care Products
- Wrinkle Fillers (Injections)
- Laser Tattoo Removal
- Skin Resurfacing (Laser, Peel, Etc.)
- Laser Hair Removal

If not listed above, please list the procedure(s) that you would like to discuss:

\_\_\_\_\_

How long have you considered this procedure? \_\_\_\_\_ Month(s) or Year(s)

What are your main concerns regarding the procedure?

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What is your price range? \_\_\_\_\_ Are you interested in discussing financing options? Yes or No

For patient's considering breast augmentation:

Current Bra Size: \_\_\_\_\_

Desired Bra Size: \_\_\_\_\_

**Implant Type:** Silicone Gel or Saline

When are your plans for surgery? \_\_\_\_\_

Have you consulted with other surgeons over this or any other procedure? YES / NO Please explain:

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### SKIN TRANSFORMATION

Please let us know if you would like information regarding the following services and procedures:

#### Exclusive Skin Care Products:

**Obagi** – a prescription strength skincare system that can actually transform you skin at the cellular level. By addressing the signs of photodamage and restoring the healthy function of your skin cells, this system is clinically proven to result in younger and healthier looking skin. Improves fine lines, age spots, rough skin, discoloration, complexion, and skin laxity.

**Obagi-C Rx** – a complete skincare program that proactively corrects early signs of damage to help restore and maintain your healthy, youthful-looking skin. It's the first and only regimen offering the benefits of both prescription-strength hydroquinone and potent vitamin C in one comprehensive system.

**Clenziderm M.D.** – prescription-strength acne therapy from Obagi Medical Products. They are the only physician-dispensed acne systems that use a liquefied form of benzoyl peroxide. And they are clinically proven to provide clearer, healthier skin in as little as two weeks!

**Kinerase** – an effective, yet gentle skin care regimen scientifically shown to improve the appearance of skin aging. The power behind Kinerase is Kinetin – a plant-based technology that helps visibly improve the appearance of aging and sun-damaged skin. Improves the visible appearance of: age-related fine lines & wrinkles, hyperpigmentation, sun damage, blotchiness.

**Latisse** – the first and only FDA approved prescription treatment for hypotrichosis used to grow eyelashes, making them longer, thicker, and darker. Eyelash hypotrichosis is another name for having inadequate or not enough eyelashes.

**Chemical Peels** for sun damage, wrinkles and acne scars

**Cosmetic consultations are complimentary. There is a \$200 charge for second opinions. Payment is due at the time of consultation. When a procedure is scheduled, a \$500 deposit is required which is non-refundable. Full payment is required at the time of the pre-op appointment or within 15 days prior to surgery. Deposits for non-surgical procedures, such as laser, are non-refundable unless the procedure is cancelled 48 hours prior to the scheduled date. It is the patient's responsibility to provide an appropriately trained translator if necessary.**

Signature \_\_\_\_\_

Date \_\_\_\_\_

## HISTORY AND PHYSICAL CONSULTATION

AGE: \_\_\_\_\_

SEX: M/F

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:**

Allergies: (include reaction)

\_\_\_\_\_

Current Medication(s) (Prescriptive or Over-the-counter):

\_\_\_\_\_

\_\_\_\_\_

Medical illnesses:

\_\_\_\_\_

\_\_\_\_\_

Previous Surgery: (Including previous cosmetic surgeries)

\_\_\_\_\_

\_\_\_\_\_

**Family and Social History :**

Occupation: \_\_\_\_\_

Spouse Occupation: \_\_\_\_\_

No. of Children: \_\_\_\_\_

History of family illness:

\_\_\_\_\_

\_\_\_\_\_

Alcohol use: \_\_\_\_\_

Special Diet: \_\_\_\_\_

Tobacco use: \_\_\_\_\_

Exercise: \_\_\_\_\_

### Review of Systems

Please indicate any history or problems with the following:

	YES	NO		YES	NO		YES	NO
WT Loss/Gain			Heartburn			Fatigue		
Fever/Chills			Reflux			Stroke		
Thyroid			Indigestion			Seizures		
Cough			Nausea/ Vomiting			Depression/anxiety		
Shortness of Breath			Hernia			Hepatitis		
Palpitations			Jaundice			Implants		
Chest pain			Urinary Symptoms			Skin or Breast Mass		
High Blood Pressure			Changes in Bowel Habit			Abnormal Mouth		
Arthritis			Hemorrhoids			Ear, Nose, Throat		
Abdominal Pain			Anemic			Diabetic		
Ulcer			Bleeding disorder			Asthma		

**CONSENT OF PRIVACY PRACTICES FOR  
PURPOSES OF PROTECTED HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, consent to the use or disclosure of my Protected Health Information by Sugene Kim, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations by Sugene Kim, M.D. I understand that diagnosis or treatment of me by Sugene Kim, M.D. may be conditional upon my consent as evidenced by my signature on this document. The release of Protected Health Information with regards to my medical treatment may be sent by fax, telephone, mail or Email to other physicians, healthcare facilities or insurance companies.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or health care operations of this practice. My treating physician at Sugene Kim Plastic Surgery, M.D., P. A. is not required to agree to the restrictions that I, the patient, may request if the restriction falls within the exceptions to confidentiality by law. However, if Sugene Kim, M.D. agrees to a restriction that I request, the restriction is binding on Sugene Kim, M.D. as my treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Sugene Kim, M.D. has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health insurance plan, my employer or a health care clearinghouse. This relates to my past, present or future physical or mental health or condition that may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review and request a copy of Sugene Kim, M.D.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Sugene Kim, M.D. The Notice of Privacy Practices for Sugene Kim, M.D. is available at my request at any time. This Notice of Privacy Practices also describes my rights and Sugene Kim, M.D.'s duties with respect to my Protected Health Information.

A. I have the right to request and be provided with a description of the procedures for exercising the following with respect to your Protected Health Information:

- (i) Inspecting and copying;
- (ii) Amending or correcting; and
- (iii) An accounting of the disclosures of such information by Sugene Kim, M.D.

Sugene Kim, M.D. may change the policies and procedures relating to Protected Health Information at any time. Should the Protected Health Information policies change, a revised Notice will be available at Sugene Kim, M.D.'s office. If you believe that there has been a violation of your Privacy Rights, a complaint may be filed with Sugene Kim, M.D., by contacting Christina Belk, Practice Manager, address: 4185 Technology Forest Blvd., Suite 150, The Woodlands, TX 77381 , or at (281) 363-4546. Further, a complaint may be filed with the U.S. Department of Health and Human Services.

**With my signature, I have been made aware of the Notice of Privacy Practices that is available at my request.**

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

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

Printed Name: \_\_\_\_\_