



SGK PLASTIC SURGERY - THE WOODLANDS

(281) 363-4546

Patient Demographic

Date: _____

Patient's Name

_____ Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact Drivers License #
Restrictions: _____ (include State) _____

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female Male

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

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

How did you hear about Dr. Kim?

(Mark all that apply)

Living Magazine Newsletter Seminar Internet Search
 Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred, may we thank them? Yes or No

Primary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____ HMO or PPO

Insured: Name _____ DOB _____ SSN _____

Relationship: _____ Employer: _____ Address: _____

Secondary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____ HMO or PPO

Insured: Name _____ DOB _____ SSN _____

Relationship: _____ Employer: _____ Address: _____

HISTORY AND PHYSICAL CONSULTATION

AGE: _____

SEX: M/F

HEIGHT: _____

WEIGHT: _____

HISTORY OF PRESENT ILLNESS:

When did the condition first occur? _____ Describe your condition: _____

If diagnosed with breast cancer, please fill out the following:

When was your diagnosis? _____ What type of cancer were you diagnosed with? _____

Which breast was effected? Right or Left Did you have radiation? Yes or No Did you have chemotherapy? Yes or No

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		

AGREEMENT OF BENEFITS

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the patient records. I hereby assign all medical benefits to Dr. Kim. I also authorize the release of information in my records to the insurance company or other parties to justify claims filed and any other pertinent parties. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

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

Signature _____ **Date** _____

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: _____