



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 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

How did you hear about Dr. Kim?

(Mark all that apply)

Living Magazine Lifestyle & Homes Magazine ReviewIt Magazine Seminar Salon Internet

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
- Chemical Peels

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?

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:

EXCLUSIVE SKIN CARE PRODUCTS

Epionce – Cosmeceutical skincare that is made up of high quality, proven ingredient formulations that therapeutically affect the appearance of the skin and helps treat symptoms of skin conditions. Epionce improves the skin's ability to heal and protect itself from the constant detrimental effects of the environment. Epionce corrects and prevents visible signs of aging, including the development of pre-existing skin conditions, while improving the overall health of the skin.

Revision – Promotes its 7 keys to unlock healthy skin: purify, refine, restore, resurface, protect, hydrate, and correct. Revision Skincare has a nice selection of products to address anti-aging, brown spots, wrinkles, and more. The products include: Teamine eye cream which has a dramatic breakthrough in treating dark circles, puffiness, and fine lines. Nectifirm is one of the best products to rejuvenate sagging skin or wrinkles on the neck and décolletage. Intellishade is a lightly tinted moisturizer with SPF 45 that is perfect for any skin type – not too heavy or too light.

NeoCutis creates a new skin, helping to speed the healing of cuts and burns while eliminating the process that leads to scarring. The **NeoCutis** line also gives the skin the proper environment to diminish and prevent visible signs of aging. **NeoCutis** products utilize Processed Skin Cell Proteins, derived from a regenerating cell bank. These proteins are rich in growth factors, antioxidants, collagen and other essential nutrients. The full line of **NeoCutis** products works in harmony to restore a smoother, softer and more vibrant tone and texture to the skin. Whether your skin has been damaged by trauma or time, **NeoCutis** helps to restore a healthier appearance, smooth away signs of aging, scarring and other forms of damage, thereby revealing a more youthful and beautiful appearance.

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. It's a once-a-day treatment that works gradually and effectively. You apply the solution topically to the base of your upper eyelashes, as instructed by your doctor. Then, results start to show in as little as 8 weeks, with full results in 16 weeks.

Clarisonic/ Opal – The Clarisonic Skin Cleansing System uses a patented sonic frequency of more than 300 movements per second while gently loosening and removing the dirt and makeup from the skin. In just 60 seconds, the Clarisonic removes 6x more makeup and 2x more dirt and oil than cleansing with your hands and is gentle enough for all skin types. The Clarisonic Opal is a palm-sized sonic infusion device specifically designed to work serum deep into the skin. The Anti-Aging Sea Serum micro-massages 7,500 times per minute into the delicate skin around the eye to help reduce the fine lines, puffiness and dark circles. The Opal is used 30 seconds around each eye immediately leaving the skin feeling firmer and more hydrated with a noticeable improvement in elasticity in as little as 4 weeks.

Cosmetic consultations are complimentary. 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 21 days prior to surgery. Deposits for non-surgical procedures, such as laser, are non-refundable. 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: _____