Dr. Sugene Kim, M.D.
SGK Aesthetics & Plastic Surgery
10080 Research Forest Drive
The Woodlands, TX 77354
Phone: 281-363-4546 Fax: 281-882-8899
www.drkimplasticsurgery.com

Patient Information Form

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: _____ SSN: _____ Email Address: _____

Employer: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

Preferred Pharmacy: Phone:

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How Did You Hear About Us?

☐ ReviewIT Magazine	☐ Lifestyles & Homes Magazine
☐ RealSelf	☐ Woodlands Online
☐ Social Media:	☐ Billboard:
☐ Doctor:	☐ Friend/Relative:
☐ Internet (website?):	☐ Other:

Failure to call and cancel your appointment 24 hours in advance or arrive for your scheduled appointment will be subject to a $100 cancellation fee. When a procedure is scheduled a $1,000.00 deposit is required. Full payment is required at the time of the pre-op appointment. Deposits for non-surgical procedures are non-refundable. We are unable to accept personal checks. It is the patients' responsibility to provide a translator.

Signature: _____ **Date:** _____

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Areas of Interest (mark all that apply):

Facial Procedures	Breast Procedures	Body Procedures	Other Services/Non-Surgical
☐ Brow Lift	☐ Breast Augmentation	☐ Abdominoplasty (Tummy Tuck)	☐ Vaginal Rejuvenation
☐ Eyelid Surgery	☐ Breast Implant Exchange	☐ Thigh Lift	☐ Botox and/or Dermal Fillers
☐ Face or Neck Lift	☐ Breast Implant Removal	☐ Arm Lift	☐ Chemical Peels
☐ Earlobe Repair	☐ Breast Lift	☐ Body Tite	☐ Microneedling/Vampire Facial
☐ Double Chin Treatment	☐ Breast Reduction	☐ Liposuction (area):	☐ Laser Treatments
☐ Face Tite	☐ Breast Reconstruction	☐ Labiaplasty	☐ Scar Revision

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

When are your plans for surgery?

What are your concerns regarding the procedure?

What is your price range? Are you interested in financing options? ☐ Yes ☐ No

Current Bra Size: Desired Bra Size:

Current Implant Type (if you have implants): Saline / Silicone Desired Implant Type: Saline / Silicone

Specific Medical History

Height: **Weight:** **Is this your goal weight?** ☐ **Yes** ☐ **No** **What is your goal weight?**

Have you or do you still have:	Yes	No	Description
Asthma, Emphysema or other breathing disorder	☐	☐	
Reflux / Heartburn / GERD	☐	☐	
High / Low Blood Pressure	☐	☐	
Heart Trouble – Palpitations or Chest Pain	☐	☐	
Hepatitis or Liver Trouble	☐	☐	
Kidney Trouble or Urinary Symptoms	☐	☐	
Diabetes	☐	☐	
Epilepsy or Seizures	☐	☐	
Stroke	☐	☐	
Problem Scarring	☐	☐	
Depression / Anxiety	☐	☐	
Thyroid	☐	☐	
Urinary Incontinence	☐	☐	
Have you been advised to or had psychiatric care?	☐	☐	

Others Not Listed:

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Medications

Are you taking any medications, vitamins or herbal or dietary supplements? ☐ No

☐ Yes, please list:

Allergies and Sensitivities

Are you allergic to medications, foods, seasonal/environmental elements or anesthesia? ☐ No

☐ Yes, please list:

Surgery and Anesthesia History

Have you ever had surgery? ☐ No

☐ Yes, please describe:

Do you have a blood relative who had anesthesia complications of any kind? ☐ No

☐ Yes, please describe:

Social History

Are you pregnant? ☐ Yes ☐ No Do you plan on having future pregnancies? ☐ Yes ☐ No

Do you…	Yes	No	Description
Smoke	☐	☐	How Much:
Drink	☐	☐	How Often:
Exercise	☐	☐	How Often:
Have children	☐	☐	How Many:
Have a special diet	☐	☐	What Type:
Use illegal drugs	☐	☐	Explain:

Date of Last Mammogram: Results: ☐ Normal ☐ Abnormal

Explanation of Results:

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

Type of cancer? When was your diagnosis?

BRCA Positive? ☐ Yes ☐ No Which breast was affected? ☐ Right ☐ Left

Did you have radiation? ☐ Yes ☐ No Did you have chemotherapy? ☐ Yes ☐ No

Additional Information:

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Family History

Have any blood relatives had any of the following?	Yes	No	Description/Relative Relationship
Cancer	☐	☐	
Bleeding Tendency	☐	☐	
Leukemia	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Repeated Infections	☐	☐	
Chronic Lung Disease / Tuberculosis	☐	☐	
Asthma	☐	☐	
Severe Allergies	☐	☐	
Kidney Disease	☐	☐	
Arthritis	☐	☐	
Mental Illness	☐	☐	
Convulsions or Fits	☐	☐	
Migraine Headaches	☐	☐	
Diabetes	☐	☐	
Gout	☐	☐	
Thyroid Trouble	☐	☐	
Obesity	☐	☐	

Others Not Listed: _____

Brilliant Distinctions Registration: The Brilliant Distinctions program allows you to earn points for each eligible Allergan treatment/product you receive from SGK Plastic Surgery. These points are redeemable for dollars off future treatments, as well as select Allergan products.

**SGK Plastic Surgery will register for you, keep track of earned points and points available to redeem as well as provide you with login information.*

Are you currently enrolled with Brilliant Distinctions? ☐ Yes ☐ No
If No, would you like to register? ☐ Yes ☐ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ **Date:** _____

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Consent to Communicate

Patient Name:

We would love to stay in touch, please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appt Reminders				
☐ Email Medical Info				
☐ Email Marketing Info				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Page	-	-	☐	-
☐ Text Appt Reminders – if so, list cell carrier:				
☐ Text Marketing Info – if so, list cell carrier:				

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____