PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____

Date of Birth: _____ Age:_____ Gender: Male Female Marital Status: M S W D

Phone (H): _____ Phone (W): _____ ext. _____ Phone (C): _____

Preferred method of contact: _____

Address: _____ City/State: _____Zip:_____

Occupation: _____ Employer: _____

Spouse or Contact person: _____Relationship _____Phone number:_____

Did another physician ***refer*** you to Dr. Choe? YES NO Referring Physician: _____

Email: _____

Referred by: (please specify in the space provided)

Self _____
Newspaper _____
Magazine _____
Employee_____
Friend _____

Relative _____
Patient _____
Spa _____
Other _____

Reason for today's visit: _____

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I authorize Dr. Choe s to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Dr. Choe's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and if applicable to process the insurance claim for services rendered at The Choe Center for Facial Plastic Surgery.

I understand that I am responsible for any balance due for professional services more than the benefits provided by my policy. I agree to pay for services not covered by my insurance policy. I understand I am responsible for obtaining any prior authorizations required by my insurance policy. I understand that in the event of collection action, I am responsible for any legal fees incurred. I consent to receiving emails & mailings for specials, events, and updates. I also consent to text and voice mail on my phone numbers for confirmation of appointments and medically related/necessary communications.

Signature: _____ **Date:** _____

PREVIOUS SURGERIES OR SERIOUS ILLNESSES

SURGERY	YEAR	SURGERY	YEAR

CURRENT MEDICATIONS

(Include all over the counter and prescription drugs; including aspirin)

DRUG / DOSE	PRESCRIBED BY:	DRUG / DOSE	PRESCRIBED BY:

_____ _____

_____ _____

List any medication(s) & material(s) that you are *allergic* or sensitive to:

_____

_____

PERSONAL INFORMATION

Height:_____ Current Weight: _____Recent Weight Loss?:_____ If yes, how much?_____ lbs.

Do you smoke? YES NO How many packs? Drink Alcohol? YES NO How much?

MEDICAL HISTORY

Have you had (Restylane, Collagen, etc.) injections? _____ Last injection? _____

Have you had Botox injections? _____ Last injection? _____

Have you ever been pregnant? YES NO How many times?_____ Live births?_____

Are you currently pregnant? YES NO

Have you recently had facial surgery? _____ Type and date: _____

Have you ever had laser resurfacing? _____ Type and date: _____

Have you had a bad reaction to local or general anesthesia? YES NO If yes, explain _____

Have you had significant emotional problems? YES NO If yes, explain _____

Have you had psychiatric care? YES NO If yes, explain _____

Have you seen other plastic surgeons about this same problem? YES NO If yes, explain _____

Do you have high blood pressure? YES NO If yes, explain _____

Do you bleed easily from cuts or surgery? YES NO If yes, explain _____

Do you form large scars or keloids? YES NO If yes, explain _____

Do you have thyroid disease or conditions? YES NO If yes, explain _____

HAVE YOU or DO YOU HAVE ANY ILLNESSES OF THE FOLLOWING? (Please circle)

Brain Nose Heart Blood Extremities Eyes Cancer

Ears Lungs Abdomen Urinary Nervous Diabetes Reproductive System

Other (Please Describe)_____

Please provide explanation if you circled any of the above_____

_____

I hereby consent to be examined and treated by Kyle Choe, MD and that the above information is correct and accurate.

Signature of patient or responsible party (please specify) **Date**