PATIENT INFORMATION (SKIN CARE)

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 contact: ____

Address: ______________________________ City/State: ____________Zip:__________

Occupation: ____________________________ Employer: ____________________________

Spouse or Contact person: ______________________Phone number: __________________

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

Email: ______________________________

Referred by: (please specify in the space provided)

Self ____________________ Relative ____________________

Newspaper ____________________ Patient ____________________

Magazine ____________________ Spa ____________________

Employee____________________ Other ____________________

Friend ____________________

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 and the practice 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:

____ ____

____ ____

<u>List any medication(s) that you are *allergic or sensitive* to:</u>

____

PERSONAL INFORMATION

Height:_________ Current Weight: _________Recent Weight Loss?:____________ If yes, how much?______________ lbs.

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

SKIN HISTORY

Have you had filler (Juvederm, Restylane, Radiesse, etc.) injections? _________ Last injection? ______________

Have you had Botox injections? ____________________ Last injection? ______________

Have ever used Latisse (eyelash grower)? Yes No

Are you currently pregnant? Yes No Are you planning more children? Yes No

Have you used Acutane? Yes No How long and when? _______________________

Have you recently had facial surgery? _______________ Type and date: _____________________

Have you ever had laser resurfacing? _______________ Type and date: ______________

Do you use tanning bed? Yes No If yes when____________________________

Do you get facial waxing/electrolysis? Yes No (consider waiting 5 days between treatments)

Do you use Retin-A/Renova/Differin? Yes No (next time discontinue use 5 days before treatment)

Do you get microdermabrasion on a regular basis? Yes No

Have you ever had a chemical peel? Yes No What kind?________________ When?_________

Are you sensitive to alcohol based products? Yes No

Tell us about your skin (circle): Normal Oily dry acne milia cysts

Do you consider your skin? (circle): Normal sensitive Resilient Not sure

Eye Color (circle): Blue Brown Green Gray Hazel Black

Hair Color (circle): Blonde Red Brown Black White

Skin Tone: Pale/white Light Medium Olive Reddish Freckled Black

What skin care products are you using on a regular basis?

____

____

____

Have you ever had a bad reaction to any skin care products? Yes No **If yes describe**

____

____

____

I consent to be examined and treated by Kyle Choe, MD and/or esthetician and that the above information is true and accurate.

____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE