*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 _____
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 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 texts, emails & mailings for specials, events, and updates. I also consent to text and voice mail on my phone numbers for confirmation of appointments and medical 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) 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? 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