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: _____ 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?

☐ Stroll Magazine (Neighborhood?)	☐ Gala (Which Non-Profit?)
☐ Real Self	☐ Woodlands Online
☐ Social Media (Which Platform?)	☐ Billboard (Location?)
☐ Doctor:	☐ Friend or Relative?
☐ Google, Bing, etc:	☐ 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)	☐ Botox and/or Dermal Fillers
☐ Eyelid Surgery	☐ Breast Implant Exchange	☐ Thigh Lift	☐ Laser Treatments
☐ Face or Neck Lift	☐ Breast Implant Removal	☐ Arm Lift	☐ Chemical Peels
☐ Rhinoplasty (Nose Job)	☐ Breast Lift	☐ Body Tite	☐ Microneedling
☐ Ear Surgery	☐ Breast Reduction	☐ Liposuction (area):	☐ Scar Revision
☐ Double Chin Treatment	☐ Breast Reconstruction	☐ Labiaplasty	☐ Vaginal Rejuvenation
☐ Chin Augmentation	☐ Gynecomastia (Men)	☐ Mons Lift (Pubic Area)	☐ Weight loss Semaglutide/Tirzepatide

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

Date of Last Mammogram: Results: ☐ Normal ☐ Abnormal

Explanation of Results:

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
ADHD	☐	☐	
Anemia	☐	☐	
Anxiety	☐	☐	
Arthritis or Gout	☐	☐	
Autoimmune Disease	☐	☐	
Bleeding Disorder	☐	☐	
Breathing Disorder	☐	☐	
Cancer	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
Epilepsy or Seizures	☐	☐	
Fatigue	☐	☐	
Heart Trouble	☐	☐	
Hepatitis	☐	☐	

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Herpes or Cold Sores	☐	☐	
High or Low Blood Pressure	☐	☐	
HIV or AIDS	☐	☐	
Kidney Disease	☐	☐	
Liver Trouble	☐	☐	
Lung Disease	☐	☐	
Migraines	☐	☐	
Obesity	☐	☐	
Problem Scarring	☐	☐	
Psychiatric Care	☐	☐	
Reaction to Anesthesia	☐	☐	
Reflux or GERD	☐	☐	
Repeated Infections	☐	☐	
Stroke	☐	☐	
Thyroid Trouble	☐	☐	
Urinary Incontinence	☐	☐	
Others Not Listed:			

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? ☐ Left ☐ Right
Radiation Treatment? ☐ Yes ☐ No Chemotherapy? ☐ Yes ☐ No

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 History

Have you ever had surgery? ☐ No

☐ Yes, please list:

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:
Use illegal drugs	☐	☐	Explain:

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Exercise ☐ ☐ How Often: _____

Eat a special diet ☐ ☐ What Type: _____

Have children ☐ ☐ How Many:

Family History

Have any blood relatives had any of the following?	Yes	No	Description/Relative Relationship
Arthritis/Gout	☐	☐	
Asthma	☐	☐	
Autoimmune Disease	☐	☐	
Bleeding Disorder	☐	☐	
Breast Cancer	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Epilepsy/Seizures	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Lung Disease	☐	☐	
Mental Illness	☐	☐	
Migraine Headache	☐	☐	
Obesity	☐	☐	
Reaction to Anesthesia	☐	☐	
Repeated Infections	☐	☐	
Severe Allergies	☐	☐	
Stroke	☐	☐	
Thyroid	☐	☐	

Others Not Listed: _____

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				
**Don't miss out on our quarterly phone sales! Enjoy specials on non-surgical treatments, skincare, and makeup for one day only. You can prepay and save on your treatments to use later. Follow us on social media for updates on upcoming specials and events! *@sgkaesthetics*				
☐ 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 i.e: injection day promotions reminders, etc.				

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

Name	DOB	Relationship	OK to Release Results?
			☐Yes ☐No
			☐Yes ☐No

Alle/Aspire Registration: The Alle/Aspire programs allows you to earn points for eligible Allergan/Galderma treatments/products you receive from SGK Plastic Surgery. These points are redeemable for dollars off future eligible Allergan/Galderma treatment/products.									
Are you currently enrolled with Alle or Aspire?	☐	Yes	☐	No	Would you like to?	☐	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: _____