3042 Oakcliff Rd Suite 200 Doraville, GA 30340

PATIENT INFORMATION

Name: _____ Sex: F ( ) M ( )

Address:_____

_____

Telephone: (H)_____(W)_____(Cell)_____

DOB:_____ Marital Status: S ( ) M( ) D( ) Other( )

Email:_____

How did you hear about us? (Check all that apply)

Google RealSelf Facebook Instagram Referral Other:_____

Emergency Contact
Name:_____
Phone: _____
Relation:_____

Patient Employment: _____
Occupation:_____
( ) Employed ( ) Retired ( ) Unemployed ( ) Minor

_____ _____
PATIENT SIGNATURE DATE

KIM
Facial Plastic Surgery

PATIENT HEALTH HISTORY

Please provide the following confidential information regarding your medical history.

NAME _____ AGE_____

Reason for your appointment - _____

Who referred you? Google RealSelf Facebook Instagram Referral:_____

	NO	YES	
Do you take any medicines?			List:_____
Are you allergic to any medicines?			List:_____
Do you smoke or chew tobacco?			How much per day? _____ How many years? _____
Do you drink alcohol?			How much? _____ How often? _____
Do you take aspirin?			
Do you bleed or bruise easily?			
Have you had any previous surgery?			List: _____
Are you pregnant?			
Are there any illnesses that run in the family?			List: _____

PATIENT HEALTH HISTORY

Do you have any of the following medical problems? If yes, please explain.

	NO	YES	
Heart Disease			
High Blood Pressure			
Diabetes			
Thyroid Problems			
High Cholesterol			
Rheumatic Fever			
Heart Murmurs			
Stomach Problems			
Liver or Hepatitis			
Respiratory Problems			
Arthritis			
Seizures/Epilepsy			
Blood Disorders			
Cancer			
Other			

What is your present occupation? _____

What occupations have you had? _____

_____

Do you have any of the following symptoms now? (Please check those that apply.)

Fever		Shortness of breath	
Weight Loss		Chest pain	
Fatigue		Abdominal pain	
Visual disturbance		Pain of urination	
Hearing loss		Muscle/joint pain	
Nasal congestion		Rash	
Sore throat		Weakness	
Hoarseness		Numbness	
Cough		Seasonal Allergies	

I certify that the above information is complete and accurate.

Patient's Signature _____

(I agree my name typed above is representing my signature)

I certify that I reviewed the above information with the patient.

Physician's Signature:_____Date:_____

KIM ENT, PC
PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that KIM ENT, PC has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Kim ENT, P.C., I understand and acknowledge the following:

1. Kim ENT has a privacy policy in effect in their offices.

2. Kim ENT has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar common area with patient access.

3. Kim ENT has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Kim ENT, P.C. and have read and understand the acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ **No,** do not want a copy but I acknowledge the Privacy Policy exists

_____ Yes, I DO want a copy of the Privacy Policy,

_____ _____

Patient Name: Date: