



TIFFANI KIM INSTITUTE

MEDICAL • WELLNESS • SPA

Today's Date: _____

(Circle One) Miss Ms. Mrs. Mr. Dr.

First Name: _____ b _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____ *Mobile: (_____) _____

Work Telephone: (_____) _____ Occupation: _____

Date of Birth: _____ Current Age: _____

Social Security Number (for insurance purposes): _____

*Email Address: _____ @ _____ . _____

How were you referred to us? _____

Have you received an email/newsletter from us? Yes No

What procedures are you interested in? (Please circle all which may apply)

Medical

- | | |
|-------------------------------------|-----------------------------------|
| Botox® | |
| Dysport® | Acne Scarring |
| Juvederm Ultra/Juvederm Ultra Plus® | Laser Treatment-Skin Rejuvenation |
| Radiesse® | Laser Treatment-Skin Resurfacing |
| Restylane/Perlane® | Laser Treatment-Tattoo Removal |
| Latisse® | |

Other: _____

Esthetics

- | | | |
|--------------------|-------------------------|--------|
| Chemical Peel | Eyelash/Eyebrow Tinting | |
| Microdermabrasion | Facial | Waxing |
| Laser Hair Removal | Skin Care Products | |

Other: _____

Who is your internist? _____ Telephone: _____

Do you object to us contacting your doctor(s)? Yes No

MEDICAL HISTORY

Have you ever had any of the following conditions?

Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Severe Headache/Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Blood Pressure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Irregular Heart Beat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Heart Disease/Angina/Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Skin Disorder (i.e. Dermatitis)Eczema,Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Hypertrophic Scarring (i.e. Keloids)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Bleeding Disorder (i.e. Anemia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Auto Immune Disease (i.e. Lupus)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____
Neurological Disease (i.e. Multiple Sclerosis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____

Previous Surgery & Anesthesia Yes No

Surgery Type	Date of Surgery	Type of Anesthesia
1.		
2.		
3.		
4.		

Current Medications (Include Birth Control and Over The Counter)		Current Herbal Supplements and Vitamins	
1.	5.	1.	5.
2.	6.	2.	6.
3.	7.	3.	7.
4.	8.	4.	8.

Habits:	Never	Frequency Of Use	# Of Years	Date Late Used
Tobacco		_____ packs/day		
Alcohol		_____ beverages/day		
Caffeine		_____ glasses/day		
Drugs Used:				

Do you use IV drugs? Yes No
 Have you had or have you been exposed to HIV (AIDS)? Yes No
 Have you ever had dental anesthesia (Novacaine)? Yes No Any bad reaction? Yes No

Allergies (i.e. Food, Latex or Medications)

Yes

No

If yes, please explain:

*****Distinguish ALLERGY (shock, hives, & swelling) from ADVERSE REACTION (nausea & upset stomach)*****

Skin

Do you have a history of any specific skin Diseases?

Yes

No

If yes, please list: _____

List Surgical procedures you have had in the last 6 months: _____

REVIEW OF SYSTEMS

Yes No **Are you pregnant or breast feeding?**
If yes, please explain: _____

Yes No **Have you recently experienced significant weight loss or weight gain?**
If yes, please explain: _____

Yes No **Have you recently experienced hair loss or nail changes?**
If yes, please explain: _____

Yes No **Have you recently experienced fevers or night sweats?**
If yes, please explain: _____

Yes No **Have you recently experienced problems with your eyes or vision changes?**
If yes, please explain: _____

Yes No **Do you wear contact lenses or eyeglasses?**

Yes No **Have you recently experienced heart, lung or chest problems?**
If yes, please explain: _____

Yes No **Have you recently experienced stomach problems?**
If yes, please explain: _____

Yes No **Have you recently experienced any difficult, frequent or painful urination?**
If yes, please explain: _____

Yes No **Have you recently experienced any difficulty hearing, frequent nose bleeds or sore throats?**
If yes, please explain: _____

Yes No **Have you recently experienced joint pain or muscle pain?**
If yes, please explain: _____

Yes No **Do you have an intolerance to heat or cold?**
If yes, please explain: _____

Yes No **Do you have any other medical concerns that have not been covered in this form?**
If yes, please explain: _____

Please add any additional information which may be pertinent to your medical history or any questions that you may have:

Patient Signature

Date

Healthcare Provider Signature

Date

Physician Signature

Date



Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

The Tiffani Kim Institute may use and disclose information for treatment, payment, healthcare operations, or as required by law.

As a patient, you have the right to inspect, copy, and make corrections to your information, to request that your information be restricted and confidential. You also have the right to a report of the disclosures of your information; and a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received of this office's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Tiffani Kim Institute. I further understand that the office will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way

Patient or Representative Name (Please Print)

Patient or Representative Signature

Date

Patient refused to sign

Patient was unable to sign because:



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Patient Consent and Authorization

My signature acknowledges that I have provided complete, accurate information and authorizes the physician to examine and treat me.

- I have received this physician's Notice of Privacy Practices.
- Federal privacy rules permit my personal and medical information to be used and disclosed without my permission for billing, medical treatment and healthcare operations. For other purposes, my information will only be released with my written permission.
- I authorize release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits directly to the physician.
- I understand that all labwork is sent to an outside laboratory and I may be billed separately by the lab and I am able to receive copies of those reports from this office.
- I understand that my insurance company may not cover services due to:
 - Lack of Coverage
 - Non-Covered Services
 - Services not meeting their definition of "medical necessity"
 - Too many services within your insurance carrier's definition of "time period"

I **DO** **DO NOT** request a chaperone in the exam room during the physical portion of my examination.

I have no objection to the doctor and/or his staff discussing my medical treatment with:

Dr. _____ (Primary Care Physician)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I DO NOT OBJECT TO:

- Phone calls to my ___ home ___ place of employment ___ cell phone.
- ___ Messages left on my answering machine/voice mail.
- ___ Messages left with one of the people listed above.

Please note: All mail will be sent to your home address and no information will be FAXed or emailed to you without your written consent.

Printed Name: _____

Signature: _____ **Date:** _____

This practice reserves the right to change its privacy practices as described in the Notice. Revised Notices will be made available upon request.

BOTOX® INFORMED CONSENT

I hereby authorize and request my healthcare provider to perform BOTOX® treatments for the purpose of cosmetic and/or medical improvements.

My health care provider has fully explained, in terms clear to me, the effect and nature of BOTOX® treatments. The foreseeable risks involved and alternative methods of treatments have also been explained to me. I understand the possible side effects/complications that could occur are as follows:

- Mild swelling, redness and/or bruising at treatment site
- Infection at treatment site
- Headache
- Localized numbness
- Rash
- Temporary eyelid or eyebrow droop

My questions have been answered to my satisfaction, and the treatment has been thoroughly explained to me. BOTOX® may be used off-label, but is FDA approved only for use in the glabella. **I understand the results are temporary, and it may take up to two weeks to see optimal results following each treatment. I understand several sessions may be needed for optimal results, and this treatment is not guaranteed, as results may vary. I understand that this treatment is non-refundable.**

If I do not see an improvement in appearance, I agree to notify the office to be seen within 14 days following my treatment.

Patient Signature: _____ Date: _____

Signature of Healthcare Provider: _____

Date: _____

- I received a copy of the BOTOX® Medication Guide _____
Initial & Date
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