To help us serve you better, please fill out the following information: Today's Date: _____/_____/_____

Name: ______________________ (Last) ______________________ (First) __________ (MI) ______________________ (Preferred)

Gender: ❑Male ❑Female **Marital Status:** ❑Married ❑Single ❑Divorced ❑Widowed **Date of Birth:** _____/_____/_____ **Age:** ________

Address: ______________________ Apt / Unit: ______________________ City: ______________________

State: ______________ **Zip:** ________________ **May we contact you by mail?** ❑Yes ❑No **May we contact you by email?** ❑Yes ❑No

Email: ______________________ **Social Security #** ______________________

Home: (_____) - ________ - __________ ❑Preferred **Cell:** (_____) - ________ - __________ ❑Preferred **May we leave phone messages?** ❑Yes ❑No

Employer: ______________________ **Work Phone:** (______) - ________ - ________ **Title:** ______________________

Whom may we contact in case of emergency? ______________________ **Phone:** (_____) - _________ - ___________

Whom may we thank for referring you? ❑Internet Search ❑Facebook / Twitter ❑Yellow Pages ❑Seminar / Event ❑ Advertisement

❑Friend (friend's name) ______________________ ❑Physician (physician name) ______________________

What procedure(s) are you interested in?

- ❑ Breast Augmentation (enlargement)
- ❑ Mastopexy (breast lift)
- ❑ Breast Reduction
- ❑ Breast Reconstruction
- ❑ Liposuction
- ❑ Abdominoplasty (tummy tuck)
- ❑ Rhinoplasty (nose surgery)
- ❑ Blepharoplasty (eyelid surgery)
- ❑ Facelift / Neck Lift
- ❑ Forehead Lift
- ❑ Otoplasty (ear pinning)
- ❑ Chin Enlargement
- ❑ Cheek Enlargement
- ❑ Scar Revision
- ❑ Belt Lipectomy (body lift)
- ❑ Labiaplasty (vaginal enhancement)
- ❑ Brachioplasty (upper arm lift)
- ❑ Thighplasty (thigh/buttock lift)
- ❑ Botox
- ❑ Dysport
- ❑ Wrinkle Fillers
- ❑ Microdermabrasion
- ❑ Chemical Peels
- ❑ Facials
- ❑ Massage
- ❑ Manicure / Pedicures
- ❑ Photofacials
- ❑ Lip Augmentation
- ❑ Laser Hair Removal
- ❑ Skin Lesion / Cancer
- ❑ Other: ______________________

____

____

What time frame for surgery are you considering?

❑ Within the next month ❑ Within the next 3 months ❑ Within the next year ❑ No specific timeframe

Have you had any previous consultations? ❑Yes ❑No

Koger Cosmetic Clinic & Medspa
4600 Military Trail, Suite 202 Jupiter Florida 33458
Ph (561) 748-1565 Fx (561)748-1568

Medical History Questionnaire

Family Physician / Internist Name: ______________________________ **Phone:** (_____)-_______-__________

Are you allergic to any medications or substances? ❑Yes ❑No If yes, please list: ______________________

____

Please list all current medications and supplements: ______________________________

____

Please list past surgeries and /or hospitalizations:

____

____

Date of last physical: ______/______/______ **Height:** ________________ **Weight:** ________________

Indicate which of the following you have had or have at present:

Breast Disease	❑Yes ❑No	Thyroid Problems	❑Yes ❑No	Bleeding Problems	❑Yes ❑No
Heart Murmur	❑Yes ❑No	Kidney Problems	❑Yes ❑No	HIV / AIDS	❑Yes ❑No
Heart Attack	❑Yes ❑No	Liver Problems	❑Yes ❑No	Hepatitis	❑Yes ❑No
Chest Pain	❑Yes ❑No	Psychiatric Care	❑Yes ❑No	Poor Healing Scars	❑Yes ❑No
Stroke	❑Yes ❑No	Lung Problems	❑Yes ❑No	High Blood Pressure	❑Yes ❑No
Seizures	❑Yes ❑No	Asthma	❑Yes ❑No	Diabetes	❑Yes ❑No
DVT	❑Yes ❑No	Cancer	❑Yes ❑No	Type(s): ____________	

Any other conditions not listed above? ______________________________

WOMEN ~ Are you currently pregnant? ❑No ❑Yes ______months **Nursing?** ❑Yes ❑No **Taking Birth Control?** ❑Yes ❑No

Do you drink alcoholic beverages? ❑Yes ❑No ~ **How many per week?** ______________________
Do you smoke? ❑No ❑Quit ~ When? __________ ❑Yes ~ **How many per day?** ________ **For how long?**__________

Family Medical History: Please list any blood relatives (Mother, Father, Siblings, Children) who have had the following:

Breast Cancer: ____________________ High Blood Pressure: ____________________
Other Cancer: ____________________ Stroke: ____________________
Diabetes: ____________________ Heart Disease: ____________________
Asthma: ____________________ Bleeding Disorders: ____________________

Are you using / taking any of the following products?
❑Benzoyl Peroxide ❑Retin A / Retinol ❑Glycolic / Lactic / Salicylic Acids ❑Differin / Tazorac / Metrogel or cream
❑Body Exfoliants ❑Hair Depilatories ❑Topical Cortisone ❑Accutane (last taken): ____________________

Do you get any of the following treatments?
❑Microdermabrasion ❑Chemical Peels ❑Fillers ❑Botox / Dysport ❑Laser / IPL /Waxing ❑Spray Tan / Suntan

Do you get Cold Sores or Fever Blisters? ❑Yes ❑No **Do you receive regular facials or skin care treatments?** ❑Yes ❑No
Do you wear sun block daily? ❑Yes ❑No **Do you have a history of lighter or darker skin color changes?** ❑Yes ❑No

Do you have any of the following concerns with your skin / complexion?
❑Acne / Problematic Skin ❑Sun Damage / Freckles ❑Rough / Uneven Texture ❑Dry / Dull Skin
❑Oily Skin / Large Pores ❑Red / Sensitive Skin ❑Wrinkles / Elasticity

Terms and Conditions of Service

In consideration of all services provided by Dr. Kim Edward Koger, M.D. and it's employees, contractors and/or affiliates, the undersigned hereby acknowledges and agrees (on behalf of himself or herself and his or her children, dependents and other persons for whom he or she serves as guarantor [collectively, "Dependents"]) with the following term and conditions of service.

Cosmetic / Spa Patient Information: Cosmetic and spa services are not covered by insurance and therefore by signing below you are acknowledging our financial policy and assume responsibility for all services rendered. Payment is due payable in full at the time of service.

For cosmetic patients, during your consultation, we will provide you with a surgical fee estimate that is valid for 3 months unless otherwise noted. The quote for the facility and anesthesia fees are quoted on the behalf of those organizations and are an estimate only. If Dr. Koger determines your surgery requires that you have pre-surgical lab work, tests or medical clearance, you are responsible for any costs associated with them. Medications, garments, transportation and any possible pathology charges, or additional facility or anesthesia fees are not included in the quote and are the sole financial responsibility of the patient. To schedule a surgical procedure, 50% of the surgical fee is due upon date selection. The balance of the surgical fee plus implants and devices is due at your pre-op appointment. Facility and anesthesia fees are paid directly to the surgery center or hospital. For your convenience, we take cash and checks as well as Care Credit, Visa, MasterCard, American Express, and Discover.

Our goal is to provide the optimal result with your plastic surgery. However, infrequently operative revisions may be required. As you know, plastic surgery is both an art and a science. If you have problems with wound healing or other factors that do not allow for optimal healing, a surgical revision may be necessary. In this instance, the surgeon's fee may be negotiable; however, you will be responsible for related fees such as operating room, anesthesia, or hospitalization. Notification of cancellation of your surgery is required at least 2 weeks prior to your scheduled surgery date. If you cancel your surgery within 2 weeks of your surgery date, 50% of the surgical fee is non-refundable. If you cancel your surgical procedure the day of surgery, no refund will be made.

Insurance Patient Information: Dr. Koger is a participating provider with **Medicare Only**. We require payment of deductibles and/or co-insurance / co-payments at the time of service. If we are not a participating provider for your health insurance, we will require that your services be paid, in their entirety, at the time of service. We are not required to file claims to insurance carriers that we are not contracted with. Please be advised that as a non-participating provider, your insurance company may deny some or all of the charges as non-covered. We are not a party to that contract as a non-participating provider.

I, the undersigned, give consent to furnish medical care and treatment to myself, or to the patient (which includes minors), for whom I am responsible. I authorize all insurance companies, other medical providers and any other entity having information concerning my healthcare to release such information to Plastic Surgery of Jupiter, P.A. I further authorize Plastic Surgery of Jupiter, P.A. to release information concerning my care to my insurance company, to assist in processing of my health care claims. If further collection efforts are required, I understand I will be responsible for collections fees, attorney's fees and/or court costs.

I, the undersigned, have completely read, fully understand and agree to the above Terms and Conditions of Service.

Signature: ______________________________ Date: ____________________

Authorization for and Release of Medical Photographs

Consent to Take Surgical and/or Spa Procedure Photographs:

Photographs are taken before and after and sometimes during a surgical or clinical / spa procedure or treatment. Consent is required to take such images. These images will not be used for any purpose other than clinical documentation.

I hereby authorize Kim Edward Koger, M.D. and/or his associates or licensees to take clinical photographs.

Signature: ____ Date: ____

Consent for Release of Surgical and/or Spa Procedure Photographs:

I hereby authorize Kim Edward Koger, M.D. and/or his associates or licensees to use pre-operative, intra-operative, and post-operative medical photographs, and/or clinical / spa treatment photographs for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purpose of medical education, patient education, lay publication, or during lectures to medical or lay groups. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Signature: ____ Date: _______________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Signature: ____ Date: ______________________________________

Addendum: Periodically we engage in self-audits and seek affiliations designed to improve the scope and quality of our services. Pursuant to these processes, we may disclose your medical information to third party agencies, entities and persons involved in credentialing our medical personnel and accrediting our medical practice and for other purposes relating to quality improvement and the auditing of care, treatment and billing. You may be asked to participate in these efforts to improve our healthcare services by answering a questionnaire or by participating in an interview. Any participation by you in these efforts will be completely voluntary.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
❑*Individual refused to sign*
❑*Communication barriers prohibited obtaining the acknowledgement*
❑*An emergency situation prevented us from obtaining acknowledgement*

❑*Other: Please specify:*____

Koger Cosmetic Clinic & Medspa
4600 Military Trail, Suite 202 Jupiter Florida 33458
Ph (561) 748-1565 Fx (561)748-1568