VIP PLASTIC SURGERY

Andrew K. Choi, M.D.
3323 W. Olympic Blvd., suite 215
Los Angeles, California 90019
Tel: 323-737-1717, Fax: 323-737-1855

PERSONAL INFORMATION

NAME: LAST_________________________**FIRST**____________________________ **DATE** ________________

HOME ADDRESS: ____

CITY: __________________ **STATE:**______**ZIPCODE:**_____________

DATE OF BIRTH: ________________ **SEX (F)**____**(M)**____ **MARITAL STATUS (M)**___ **(S)**___**(D)**___**(W)**___

TELEPHONE: (H) ___________________ **(W)** _______________ **(CELL)** _________________________

E-MAIL ADDRESS:____ **FAX:**_____________________________

CONSULTATION INFORMATION

PLEASE CIRCLE BELOW THE TYPE OF SURGERY YOU ARE INTERESTED IN DISCUSSING:

NOSE FACE UPPER-EYELID LOWER- EYELID NECK MOUTH EARS SCARS CHEEKS
CHIN WRINKLES BOTOX FACIAL-FILLER FAT TRANSFER SPOT OTHER_________________

WHY DID YOU SELECT OUR CENTER?

___**Patient referral** ___**Doctor referral** ___**Friend or Family** ___**Newspaper** ___**Internet**

___**Magazine Which Magazine?** ______________________________ ____**Directory/ Yellow pages**

___ **Other(Please indicate)** ____

Have you had any other previous cosmetic, plastic surgery? ______**Yes** ______**No**

When______________ **and what surgery have you done?** ____________________________________

CONSENT TO TREATMENT OF MINOR

I (we) being the parent(s) or guardian of____
a minor being the age of _________ **do hereby consent, authorize and request to administer such treatment deemed advisable, necessary or requested on the above-named minor.**
I (we) agree to hold her (him) free and harmless from any claims, suits, for damages or complications which may result from treatment.

Patient Signature ____ **Date**________________________