Andrew K. Choi, M.D., FACS

PATIENT INFORMATION

Last name: _____First name: _____ Sex: (F / M)

Home address: _____

City: _____State:_____Zip code:_____

Date of birth: _____ ***Email:** _____

****Wechat / Kakao: Yes / No***

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

Emergency contact: Name: _____Phone: _____Relationship_____

*****HOW DID YOU SELECT OUR CLINIC?***

___***Patient referral*** ___***Doctor referral*** ___***Friend or Family***
___***Newspaper*** ___***Internet(Yelp/RealSelf)*** ___***Magazine***
___***Directory/Yellow pages*** ___***Other (please indicate)***_____

CONSULTATION INFORMATION

Please circle below the type of surgery you are interested in discussing:

Eyes & Brow:
Eye surgery / Eye bag / Sleepy eye / Brow Lift / Other: _____

Nose: Nose surgery / Had nose surgery before? (Yes/No) / Other: _____

Chin & Cheek: Augmentation / Reduction

Breast: Augmentation / Reduction

Jaw Reduction

Facelift: Surgery / EndyMed / Ultherapy / Thermage / Thread Lift

Liposuction / Fat Graft: Which area?_____ / Tummy Tuck

Botox & Filler Injection Stem Cell Treatment(Lightening/Anti-Aging) Micro Needling Treatment

IPL Chemical Peel Other: _____

CONSENT TO TREATMENT OF MINOR

I (We) being the parent(s) or guardian of _____, a minor being the age of under 18, 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/Guardian Signature:_____Date:_____