

KUNG PLASTIC SURGERY, P.A.

David S. Kung, M.D., F.A.C.S.
5454 Wisconsin Avenue
Suite 635
Chevy Chase, MD 20815-5910

Patient's Name _____
(First) (Middle) (Last)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Social Security: _____ - _____ - _____ Birth Date: _____ Age: _____ Sex: _____

Known Medical Problems: _____ Allergies _____

Marital Status: _____ Emergency Contact: _____

Referred by: _____ Reason: _____

Email: _____

INSURANCE

Primary Insurance Co.: _____ Phone: () _____

Policy #: _____ ID# _____

Address: _____

Name of Policy Holder: _____ Employer: _____

Policy Holder Birth Date: _____ Social Security Number: _____

Secondary Insurance Co: _____ Phone: () _____

Policy #: _____ ID #: _____

I hereby authorize kung plastic surgery, P.A. to bill my insurance company for services rendered to me and/or my family. I understand that these payments are made directly to the doctor. I understand that this in no way relieves me of my primary responsibility to pay for services to me (or my minor child). If my account is referred to an attorney for collections. I agree to pay any reasonable legal fees (25% is deemed reasonable), court costs, and other collection expenses. I certify that the information provided about my insurance company is correct. I authorize the release of medical information requested by my insurance company. A copy of this form can be sent to my insurance company in lieu of a signature when necessary. I am responsible for the balance after the insurance payment.

Printed Name of Patient Or Responsible Party Date

Signature of Patient Or Responsible Party Date

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulders

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Date of last menstrual period _____
 Date of last Pap Smear _____
 Have you had a mammogram? _____
 Are you pregnant? _____
 Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____ Phone _____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Occupational

Check (✓) if your work exposes you to:

	Stress	Hazardous Substances
	Heavy Lifting	Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date



KUNG PLASTIC SURGERY, P.A.

301.986.8878

301.986.8879 fax

dk@kungmd.com

www.kungplasticsurgery.com

5454 Wisconsin Avenue, Suite 636, Chevy Chase, MD 20815-5910

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____