K. Kay Durairaj, MD, FACS, A Medical Corporation

New Patient Registration Form

Today's Date: _____

PATIENT INFO:

Last Name: _____ First Name: _____ MI: _____ Sex: F / M

Age: _____ DOB: _____ SSN: _____-_____-_____ DL#: _____

Address: _____ Suite/Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Height: _____ Weight: _____ Email: _____

Ethnicity: _____ Race(s): _____ Please Indicate: Hispanic / Non-Hispanic

Preferred Language: _____ May we leave detailed health messages on your voicemail?: Y / N

Contact Restrictions?: Y / N If Y, please specify: _____

Instagram: @_____ Snapchat: @_____

Approval to send you information on products and services, including sales and special offers?: Y / N

WORK INFO: (If patient is a minor, give patient/guardian employment information)

Are you employed?: Y / N If Y, please specify name of employer: _____

Occupation/Job Description: _____ Work Phone: _____

Work Address: _____

EMERGENCY INFO:

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

REFERRALS:

How were you referred to our office?: _____

Primary Care Physician: _____ Phone: _____

Please note, cosmetic procedures and products are not covered by insurance and procedures are on a cash-based service.
There are no warranties or guarantees implied or specific about my cosmetic outcomes.
We do not offer refunds on procedures.

Name: _____ **DOB:** _____ **Date:** _____

MORE INFO:

Specific problem/area(s) for which you are seeking care: _____

Have you consulted other doctors about this?: Y / N If Y, please specify: _____

Do you have any drug allergies?: Y / N If Y, please specify: _____

Type of reaction experienced: _____

List of medical conditions, major illnesses, or injuries: _____

List any surgeries you have had: _____

List any major medical problems of family members: _____

List any medications taken: _____

SOCIAL HISTORY & LIFESTYLE:

Marital Status: Single Married Divorced Widowed

Have you received radiation in the past?	Y	N	If Y, please specify: _____
Do you smoke cigarettes/chew tobacco?	Y	N	Or, quit date: _____
Do you drink alcohol?	Y	N	If Y, number of drinks per day: _____
Do you take recreational drugs?	Y	N	If Y, please specify: _____

Other health info: _____

Please check any concerns and/or additional services that you are interested in:

____ History of skin cancer or melanoma	____ Acne	____ Prominent scar
____ Dark spots on skin	____ Loose skin	____ Mole removal
____ Thinning of eyebrows/lashes/hair	____ Oily skin	____ Excessive veins
____ Injectable treatments and dermal fillers	____ Wrinkles	____ Tired or droopy eyes

What skin procedures and/or treatments have you had in the past?: _____

Do you have a tendency to redness?: Y / N Do you ever experience flaking or tightness of your skin?: Y / N

Have you ever had a reaction to products/treatments?: Y / N If Y, please specify: _____

Have you ever had a chemical peel?: Y / N If Y, please specify type: _____

Are you trying to become pregnant?: Y / N Do you have a history of fever blisters and/or cold sores?: Y / N

I give my consent for evaluation and treatment from the office of Dr. Kay Durairaj.

_____ _____

Signature of Parent, Guardian, or Personal Representative Date

The Office of Dr. K. Kay Durairaj, MD, FACS | 800 South Fairmount Avenue Suite 325 Pasadena, CA 91105
Office: 626.316.7033 | Fax: 626.539.2529 | info@beautybydrkay.com | www.beautybydrkay.com | IG: @BeautyByDrKay |SC: @Dr_Kay

Name: _____ DOB: _____ Date: _____

Audio/Photo/Video Media Release Form

I grant permission to K. Kay Durairaj, MD, FACS and its agents or employees to use photographs and/or video and audio taken of me. These images may be used in educational and documentary materials, such as Public Service Announcements, Grant Applications, Video Documentaries, and both printed and online accounts, such as Instagram, Snapchat, Facebook, and any other purposes in connection with the program deemed appropriate and necessary by K. Kay Durairaj, MD, FACS.

I hereby agree to release, defend, and hold harmless K. Kay Durairaj, MD, FACS and its agents or employees, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper, via electronic media, or on websites, from any claim, damages, or liability arising from or relating to the use of the photographs/video, including but not limited to any misuse, distortion, blurring, alteration, optical illusion, or use in composite form, either intentionally or otherwise, that may occur or be produced in taking, processing, reduction, or production of the finished product, its publication, or distribution.

I am 18 years of age or older and have read this release before signing below, fully understanding the contents, meaning, and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

____ I give consent.

____ I do not give consent.

_____ _____

Printed Name DOB

_____ _____

Signature of Parent, Guardian, or Personal Representative Date

Name: _____ DOB: _____ Date: _____

Patient-Provider E-mail Agreement

Email offers an easy way for patients and doctors to communicate. In many circumstances, it can have advantages over office visits and telephone calls. But remember, there are **differences**. E-mail is not the same as calling our office; you can't tell when your message will be read, or if your doctor is in the office. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in your e-mail subject line. Below are our rules for e-mail contact.

- E-mail is never, ever appropriate for urgent or emergency problems! Please use the telephone or go to your nearest hospital's emergency room for emergencies.
- E-mail is great for asking little questions that don't require much discussion. Appropriate uses also include prescription refill requests, referral/appointment scheduling requests, and billing/insurance questions.
- E-mails should not be used to communicate sensitive medical information.
- E-mail is not confidential. My staff may read your e-mails to handle routine, non-clinical matters. If sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of your medical record; a copy may be printed and saved in your chart.
- E-mail is not suitable for seeing me. If you think you might need to be seen, please call for an appointment.
- E-mails may be forwarded to my staff for handling, if appropriate.
- Remember, e-mail services such as Google, Yahoo, Hotmail, and various other providers do not promise complete privacy. They are not HIPAA-compliant and are not encrypted.
- Finally, either one of us can revoke permission to use the e-mail system at any time.

I DO want to communicate with Dr. Kay Durairaj's office electronically. This includes occasional informational newsletters. I have read the above information, and understand the limitations of security on information transmitted. I understand that Dr. Kay Durairaj may not be able to communicate with me electronically about my specific condition if I live outside the state in which she is licensed. Should you choose to communicate with us via e-mail, please add our address, **info@beautybydrkay.com** to your address book.

_____ _____

Email address Name

_____ _____

Signature DOB