ADULT • PEDIATRIC
SURGICAL • COSMETIC

JULIA KAUFFMAN, M.D.
SARAH PINNEY, M.D.
BOARD CERTIFIED DERMATOLOGISTS

915 GESSNER RD, SUITE 640
HOUSTON, TX 77024
PHONE: 713-984-2222
FAX: 713-467-6980

PATIENT REGISTRATION

Today's Date: ___/___/___ Name: ____

Address: ____

City/State/Zip: ____

Home Phone: __________________ Work Phone: _________________ Cell Phone:_________________

Email Address: ___________________________________ Preferred Contact: ❒ Cell ❒ Home ❒ Work

Date of Birth: ______/_______/_______ Age: ________ Sex: ☐ M ☐ F Marital Status: ______________

Social Security Number: ______- _______ - ________

Emergency Contact: _______________________________________ Phone Number: _______________

Relationship of Emergency Contact: ____

Name of Parent or Guardian (if patient is a minor): ____

MEDICARE Insurance	**Secondary Insurance**
Insured's Name: _____________________________ Social Security Number: ______________________ Member ID Number: __________________________ ❒ Self ❒ Spouse ❒ Child ❒ Other Insured's Date of Birth: ______/______/_______	Secondary Insurance: ________________________ Insured's Name: ______________________________ Social Security Number: ______________________ Policy #: ____________________________________ Group #: ____________________________________ ❒ Self ❒ Spouse ❒ Child ❒ Other Insured's Employer: __________________________ Insured's Date of Birth: ______/______/_______

Patient's Employer: ____

Occupation: ____

Full-Time Student? ☐ Yes ☐ No

How did you hear about us? ❒ Physician ❒ Family member ❒Friend ❒ ZocDoc
❒Employer/Insurance Company ❒Google/Internet Search ❒Magazine/Phonebook
❒ Other: ____

I understand that office visit charges are payable on the day service is rendered. I authorize the office of Julia Kauffman, M.D. and Sarah Pinney, M.D. to bill my insurance company if applicable. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between the office of Julia Kauffman, M.D. , Sarah Pinney, M.D. and myself.

Signature: ___________________________________ Date: ____________________________

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MEDICAL HISTORY

Today's Date: ______/_______/_______ Name: ____

The reason for your visit: ____

Weight: ____________________ Age: _____________________

Primary Care Physician: _____________________________________ Phone: _______________________________

Please list all medications you are currently taking: ____

____

____

Drug Allergies: ____

Are you interested in treating wrinkles, skin texture, skin tone, reversing sun damage, or facial rejuvenation? ❒ Yes ❒ No

Medical History: (Please check)

❒ AIDS/ HIV
❒ Allergies/Sinus Problems
❒ Arthritis
❒ Artificial Heart Valve
❒ Asthma
❒ Atypical Moles
❒ Bleeding/Clotting Problem
❒ Breathing Difficulty
❒ Cancer
❒ Chest Pain/tightness
❒ Cold Sores/ Fever Blisters
❒ Congestive Heart Failure/ Heart disease/ Heart Attack
❒ Depression/ Biopolar disorder
❒ Diabetes
❒ Excessive Sweating
❒ Glaucoma
❒ Hair Loss
❒ Headaches
❒ Heart Attack
❒Heart Disease
❒ Heart Murmur
❒ Hepatitis (current or past infection)
❒ High Blood Pressure
❒ High Cholesterol
❒ Hives
❒ Inflammatory Bowel Disease
❒ Joint Replacement
❒ Keloids (thick scar)
❒ Kidney Problems/ Kidney Stones
❒ Migraines
❒ Mouth Ulcers
❒ Osteoporosis/ Osteopenia
❒ Pacemaker/ Defibrillator
❒ Seizures
❒ Skin Cancer
❒ Skin Condition
❒ Stroke (Cerbral Vascular Accident)
❒ Thyroid Problems
❒ Tuberculosis
❒ Xray Therapy
❒ Other____________________

Please list any previous surgeries: ____

____

For Women: Are you currently pregnant, actively trying to get pregnant OR breastfeeding? ❒ Yes ❒ No

Social History:
Do you wear sunscreen regularly? ❒ Yes ❒ No Use tanning beds? ❒ Yes ❒ No

Family History:

Condition	Family Member (Relationship)
-No Relevant Family History	
-Unknown - Adopted	
Arthritis	
Autoimmune Disorders	
Bleeding/ Clotting Problems	
Cancer	
Diabetes	
Eczema	
Endocrine Disease	
Heart Disease	
High Blood Pressue	
Malignant Melanoma	
Other	
Psoriasis	
Skin Cancer (basal cell carcinoma, squamous cell carcinoma)	
Skin Disease	
Stroke	

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NOTICE OF PRIVACY AND HIPAA

Today's Date: ______/______/_______ Name: ____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

May we leave a message on your preferred contact number regarding **medical results**? ❐ Yes ❐ No Telephone: ________________

Do we have permission to discuss your medical condition with a family member? ❐ Yes ❐ No

If yes, who? ______________________ Relationship: ________________ Telephone:_________________

The office of Julia Kauffman, M.D. and Sarah Pinney, M.D. has provided me with a copy of my rights (find a copy on our web site or ask for a copy in the office) as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have any questions, please address them with the physician during your visit.

I acknowledge the office of Julia Kauffman, M.D. and Sarah Pinney, M.D. has made the Notice of Privacy Practices available to me. I authorized release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physicians.

Signature: ____________________________________ Date: ___________________________________