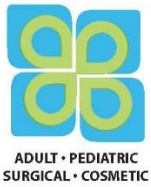

JULIA KAUFFMAN, M.D.
SARAH PINNEY, M.D.
BOARD CERTIFIED DERMATOLOGISTS

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: _____

ADULT • PEDIATRIC
SURGICAL • COSMETIC

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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: _____