IRIS S. POLINGER, M.D.,PH.D., P.A.
DIPLOMATE OF THE AMERICAN BOARD OF DERMATOLOGY
DERMATOLOGY AND DERMATOLOGIC SURGERY

1415 Hwy 6 South, Bldg C-400
Sugar Land, Texas 77478

(281) 491-9278

Fax (281) 491-3376

Patient Registration

Patient Information (Fill out Completely) AGE_____

Last name _____ First_____ M_____ DOB_____

Home Address_____ City_____ ST_____ Zip_____

Sex M _____F_____ Marital Status (Circle One) Married Single Divorced Widow

Home Phone_____ Work Phone_____ Cell Phone_____

Patient Employer or School_____ SSN_____

Relationship to Responsible Party_____ Driver License # _____

Emergency Contact Name _____Phone_____ Relation_____

Email_____

Patient Referred By

Dr.(name) _____Address_____ Phone_____

Yellow Pages ___ Newspaper ___ TV ___ Other _____ Patient _____

How long have you
had skin trouble?_____ Location on Body _____

Present Treatment _____

List any medication you take _____

Vitamins _____ Birth Control_____ Laxatives _____ Heart _____

Past Medical History: (Please Check All That Apply to You)

Smoking _____ Lung Disease _____ Asthma _____ Drinking _____ Cancer (Type) _____

Eczema _____ Fainting _____ Skin Disease _____ Easy Bleeding _____ Diabetes _____

Tuberculosis _____ Seizures _____ Ulcers _____ Hay Fever _____ Hives _____ Epilepsy _____

High Blood Pressure _____ Heart Disease _____ Hepatitis _____ Kidney Disease _____ HIV+ ____

AIDS _____ Other _____

List any operations _____

Family Skin Disease: Yes __ No__ Do you wear a pacemaker? Yes __ No __

Ladies: Do you think you might be pregnant? Yes ___ No ___ Tubal Ligation? ____ Nursing? _____

Are you allergic to any medication? _____

Do you have ANY allergies? _____

SIGNATURE of parent or legal Guardian: Required to treat a child under age 18 _____

CONSENT TO TREAT: I hereby consent to treatment by my dermatologist Dr. Iris S. Polinger to include examination, treatment, surgery and prescription of medication (s). **SIGNATURE**:

_____

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Financial Responsibility Statement: For and in consideration of the medical services rendered, and to be rendered to me or the patient named above and for the further consideration of the extension of credit by Iris S. Polinger M.D., Ph.D., P.A. it successor assigns, all fees and expenses incurred by said patient, including attorney's fees, if such patient's account is turned over to an attorney for collection. This guarantee shall be considered continuing in nature and shall remain in effect until revoked by me in writing**.** *Patient is also responsible for payment of services rendered in full if payment is denied by insurance company due to preexisting limitations listed on insurance policy or student status not covered.*

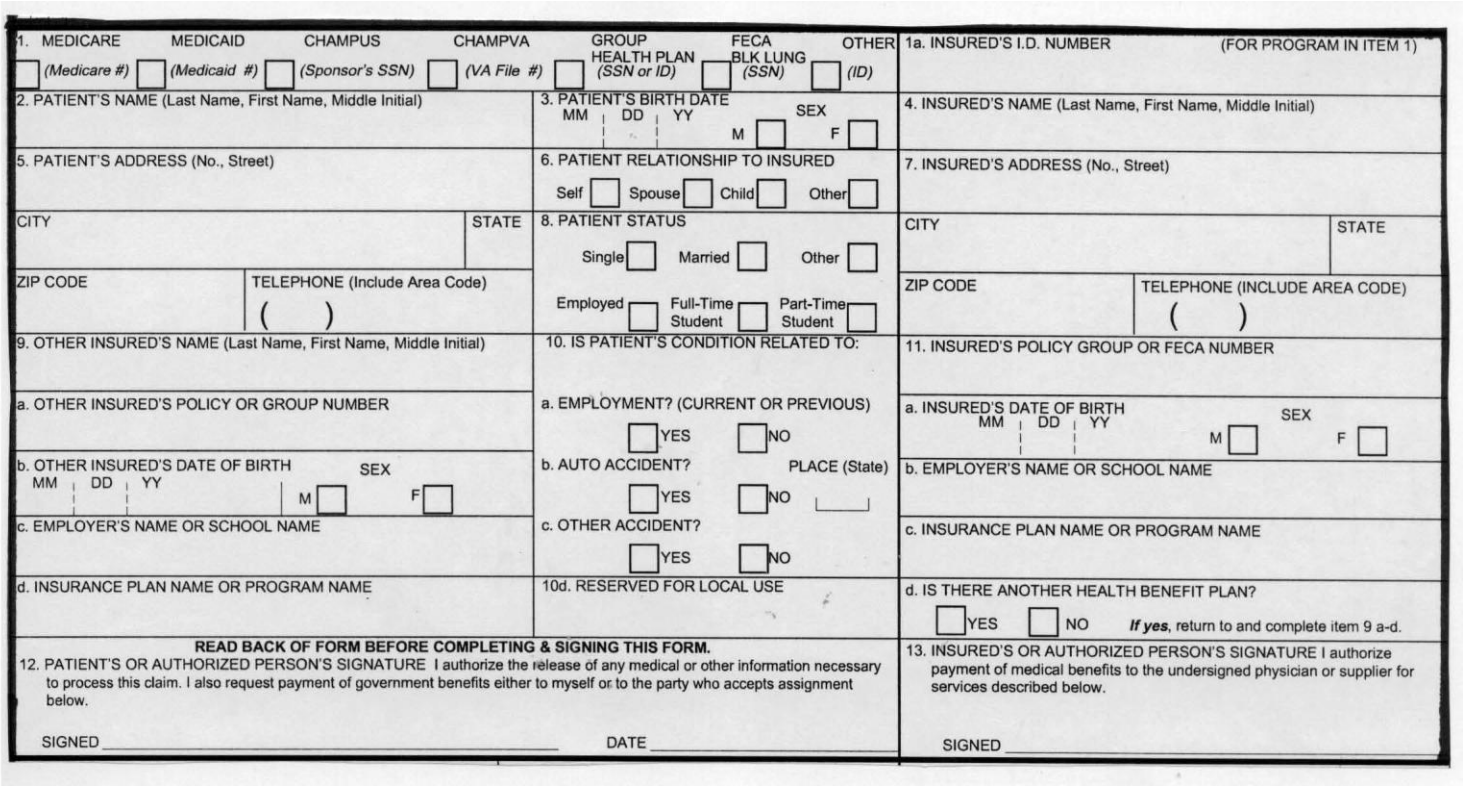
Patient or Guarantor Signature: _____ Date: _____

To Whom It May Concern: I hereby authorize you to release to my insurance company listed on this page any information, including the diagnosis and records of any treatment or examination rendered to me during commencing first date of service.

Patient or Guarantor Signature: _____ Date: _____

Guarantor of Insurance Information

Driver's License Number _____



1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the used and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practice* to sign this consent. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bounded to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement to this *Notice of Privacy Practices* Acknowledgement but was unable to do so as documented below:

Date: Initials: REASON:

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Cosmetic Interest Questions

Patient Name: _____ Date:_____

Dr. Polinger offers these services to our patients to assist in anti-aging and skin health needs in a safe and familiar environment.

These are areas of concern for me (please circle all that apply)

Cosmetic Makeover	Microdermabrasion	Laser Treatments
Skin Care Advice	Chemical Peels	Laser 360
Acne	Smokers Lines	Acne Laser
Brown Spots/ Melasma	Crow's Feet	Excess unwanted Hair
Red Face	Sun Damage Face, Chest, Hands	Tighten Neck Skin
Dandruff	Fine lines and Wrinkles	Laser Hair Removal
Dryness	Lines around nose, mouth, eyes or Lips	Sclerotherapy- Leg vein Injections
Enlarged Pores	Thin or Small Lips	Leg Vein Laser
Rough Texture of Skin	Frown Lines	Acne Scars or Gouges
Uneven Skin Tone	Botox	Pixel Fractionated Resurfacing Laser
Freckles	Restylane	Photofacial laser
Circles under eyes	Juvéderm	Sagging Skin
Sunscreen Advice	RADIESSE	Redness / Rosacea
Eyelash Enhancement	Unwanted hanging skin under chin	Other:

WHAT IS THE BEST WAY TO CONTACT YOU

_____

COUPON
10% OFF FIRST COSMETIC TREATMENT.
Only for first time cosmetic patients. One time use only for any one of the procedures listed above. *Exclusion: Care Credit.

Can you tell us a bit about your current skin regimen?

PLEASE RETURN TO NURSE