



NEW PATIENT REGISTRATION

Today's Date: _____

Please complete the following information for our records at Zimmet Vein & Dermatology.

Last Name:	First Name:	Middle Initial:
Street Address:		
City:	State:	Zip:
Age:	Birth Date:	Social Security#:
Driver's License #:	Expiration Date:	
Home Phone:	Work Phone:	
Cell Phone:	Email Address:	
Primary Care Physician:	Referred By:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Employer:		
Spouse's Name:	Phone Number:	

WOULD YOU LIKE TO JOIN OUR ZNEWS MAILING LIST? Yes No

We'll keep you up-to-date via email on new treatments, events and specials. Your privacy is important to you and us. Your information will not be shared with other parties.

ARE YOU CURRENTLY COVERED BY MEDICARE? Yes No

PLEASE COMPLETE THE FOLLOWING IF THE PATIENT IS A MINOR:

Name of Person Completing Form:	Last Name:	First Name:
Relationship to Patient: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other:		
Address (if different from patient):		
Phone Number:		

EMERGENCY CONTACT (OTHER THAN HOUSEHOLD MEMBER):

Last Name:	First Name:	Middle Initial:
Relationship to Patient:	Phone Number:	
Address:		
City:	State:	Zip:

PLEASE READ & SIGN:

I AUTHORIZE STEVEN E. ZIMMET, MD TO RELEASE MEDICAL INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY.

Signed: _____ Date: _____

PAYMENT IS DUE AND PAYABLE AT THE TIME THAT SERVICES ARE RENDERED. I UNDERSTAND I MAY RECEIVE SEPARATE BILLS FOR CERTAIN SERVICES PROVIDED OUTSIDE THIS OFFICE, SUCH AS RADIOLOGY OR LABORATORY SERVICES. I CERTIFY THAT THE INFORMATION ABOVE IS CORRECT.

Signed: _____ Date: _____



PATIENT HISTORY FORM

Patient Name: _____

Date: _____

Date of Birth: _____

MEDICAL HISTORY

(Check as many as apply)

	Y	N		Y	N		Y	N
Anemia/Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Are You Breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Any Metal Implants? <i>(Please specify)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<i>(Please specify)</i>			_____		
Keloids/Abnormal Scars	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Pigmentation Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Poor Wound Healing	<input type="checkbox"/>	<input type="checkbox"/>	_____					

CURRENT MEDICATIONS

(Check as many as apply)

	Y	N
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinner	<input type="checkbox"/>	<input type="checkbox"/>
Heart Medication	<input type="checkbox"/>	<input type="checkbox"/>
Hormones	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Other Medications	<input type="checkbox"/>	<input type="checkbox"/>

(Please specify)

MEDICATION ALLERGIES

(Check as many as apply)

	Y	N
Lidocaine	<input type="checkbox"/>	<input type="checkbox"/>
Novocaine	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>

(Please specify)

Is there anything else you feel we should know about your medical history?

HOW DID YOU HEAR ABOUT US?

<input type="checkbox"/> Physician Referral: <i>(Please specify)</i>	_____	<input type="checkbox"/> Friend Referral:	_____
<input type="checkbox"/> Website (www.skin-vein.com)	_____	<input type="checkbox"/> Living Social	_____
<input type="checkbox"/> Google	_____	<input type="checkbox"/> Groupon	_____
<input type="checkbox"/> Yahoo!	_____	<input type="checkbox"/> Print Ad: <i>(Please specify magazine)</i>	_____
<input type="checkbox"/> Citysearch	_____	<input type="checkbox"/> Other:	_____
<input type="checkbox"/> YELP	_____		_____



SKIN & VEIN CARE NEEDS

To help us provide you with the services you desire and the best treatment possible, please answer a few questions regarding your skin and vein care needs.

Patient Name: _____

Date: _____

YOUR SKIN AND VEIN CARE NEEDS:

Please indicate your concerns about your skin or veins.

<input type="checkbox"/> Aging Chest and/or Neck	<input type="checkbox"/> Lip Enhancement	<input type="checkbox"/> Spider Veins (facial)
<input type="checkbox"/> Aging Skin- Face	<input type="checkbox"/> Non-invasive Fat Removal	<input type="checkbox"/> Spider Veins (legs)
<input type="checkbox"/> Crows feet	<input type="checkbox"/> Pigmentation problems	<input type="checkbox"/> Sun damage
<input type="checkbox"/> Frown lines	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Wrinkles
<input type="checkbox"/> Hair removal	<input type="checkbox"/> Saggy/loose skin	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Hand Veins	<input type="checkbox"/> Scars	
<input type="checkbox"/> Hyperhidrosis (Sweating)	<input type="checkbox"/> Smile lines	

Other: _____

OUR COSMETIC DERMATOLOGY, LASER TREATMENTS, VEIN AND SPA SERVICES:

Please indicate the procedures or treatments you would like additional information about.

COSMETIC DERMATOLOGY	LASER TREATMENTS	VEIN SERVICES	SPA SERVICES
<input type="checkbox"/> Acne/Acne Scarring	<input type="checkbox"/> Coolsculpting	<input type="checkbox"/> Spider Veins	<input type="checkbox"/> Skin care advice
<input type="checkbox"/> Botox	<input type="checkbox"/> Facial Veins	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Products
<input type="checkbox"/> Coolsculpting	<input type="checkbox"/> FotoFacial Plus	<input type="checkbox"/> EVLT	<input type="checkbox"/> Facials
<input type="checkbox"/> Fillers	<input type="checkbox"/> Fractional CO2	<input type="checkbox"/> Foam Sclerotherapy	<input type="checkbox"/> Chemical Peel
<input type="checkbox"/> Peels	<input type="checkbox"/> Hair Removal	<input type="checkbox"/> Phlebectomy	<input type="checkbox"/> Gentlewaves
<input type="checkbox"/> Thermage- Eyelids	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Sclerotherapy	<input type="checkbox"/> Microdermabrasion
<input type="checkbox"/> Thermage- Face	<input type="checkbox"/> Thermage	<input type="checkbox"/> Ultrasound testing	<input type="checkbox"/> Lash & Brow Tinting

Other: _____



Patient Consent for Use of Email Communications

To better serve our patients, Zimmet Vein and Dermatology has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at zimmet@skin-vein.com. This form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 hours.

If you require urgent or immediate attention, this medium is not appropriate. Please call our office at 512-485-7700 or call 911 if this is an immediate medical emergency.

When sending email communications, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, date of birth and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

Patient's Signature

Date