



JUNIPER

DERMATOLOGY

Tel 512-808-4777 Fax 512-808-4779
3801 N Capital of Texas Hwy, Suite J225
Austin, Texas 78746
www.juniperderm.com

Bryan L. Gammon, MD, MBA, FAAD

Loebat Kamalpour, MD, FAAD

Patient Information:

Patient Name _____

Address _____ City _____ State _____ Zip _____

Home #. () _____ Work #. () _____ Cell #. () _____

Email Address: _____

Prefer we contact you by: Cell _____ Home _____ Work _____ Email _____

Birth Date _____ Age _____ Sex _____ Driver License # _____

SS# _____ Marital Status _____ Spouse's Name _____

Employer/Occupation _____ Student: Full time _____ Part time _____

Emergency contact: Full Name : _____

Relationship to pt. _____ Tel. #. _____

Referral information: Who referred you to us? _____

Primary Physician's Name _____ Tel. # _____

Race: Caucasian _____ Asian/Pacific Islander _____ Other _____ Refuse to provide _____

Ethnicity: Hispanic/Latino _____ African _____ American Indian _____ Other _____ Refuse to provide _____

Prof. Language: English _____ Spanish _____ Other _____

Insurance Information: Name and date of birth of policy subscriber: _____

Initial applicable statement

___ **Bill my insurance plan.** I have provided my insurance information to office staff. I will pay applicable co-payment and charges for non-covered services at time of service and be billed for any balance remaining after insurance consideration.

___ **Out of network.** It is my understanding Juniper Dermatology does not participate with my insurance. I agree payment is expected at time of appointment and insurance claim submission is my responsibility.

___ **I will pay at time of service.** I do not wish to provide insurance information.

Responsible party:

Name _____ Relationship _____

Mailing Address _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Birth date _____ Sex _____ SS# _____ - _____ - _____ DL# _____

I understand the office financial policy requires payment in full at time of service unless services are covered by an insurance plan in which Juniper Dermatology has a participating agreement. I understand charges for treatment are my responsibility, regardless of insurance. I authorize release of medical records to my physician and insurance company.

Signature of Patient or Responsible Party _____ **Date** _____



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HIPAA Authorization Release of Information

Patient Name: _____ **Date of Birth** ____/____/____

Release of Information

I authorize the release of information including the diagnosis, examination of records, claims information, and billing information. This information may be released to:

Spouse: _____

Children: _____

Parents: _____

Other: _____

Information is not to be released to anyone

This release of information will remain in effect until terminated by me in writing.

Phone Messages

Please call my home _____

my work _____

my mobile phone _____

If unable to reach me:

Please leave a detailed message

Please leave a message asking me to return the call

Signature: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

parent or guardian of minor patient guardian or conservator of an incompetent patient



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What Skin Concerns Bring You to the Office? _____

Do you have any interest in cosmetics/skin care products? _____

Drug Allergies _____

Current Medications _____

Last Physical Examination _____

Smoker: Current smoker ___ Never smoked ___ Former smoker ___

Alcohol Use: Denies use ___ Socially ___ Daily ___ Preferred Pharmacy: _____

Patient Past Medical History (circle all that apply)

None	Anxiety	Arrhythmia	Asthma	BPH
Bleeding Disorder	Breast Cancer	Bronchitis/COPD	Cancer	Cerebral Palsy
Chest Pain/Tightness	Dementia	Depression	Diabetes	Eczema
GERD	Glaucoma	Gout	Heart Disease	Heart Murmur
Hepatitis/HIV	High Blood Pressure	Hives	Hyperlipidemia	Incontinence
Kidney Disease	Kidney Stones	Lymphoma	Multiple Sclerosis	Osteoarthritis
Osteoporosis	Parkinson's disease	Rheumatoid Arthritis	Seasonal Allergies	Sjogren's Syndrome
Stroke	Thyroid Disorder	Tuberculosis	Ulcers	Xray Therapy

Other: _____

Patient Past Surgeries/Hospitalizations

Surgery/Hospitalizations	Date	Anesthesia Complications	Notes

Skin History (circle all that apply)

None	Acne	Actinic Keratosis	Basal Cell Carcinoma
Bullous Pemphigoid	Eczema	HSV	Lichen Planus
Lichen Sclerosus	Malignant Melanoma	Psoriasis	Rosacea
Sjogren's	Squamous Cell Carcinoma	Urticaria	Vitiligo

Patient Family History (circle all that apply. Note afflicted family member)

None	Abnormal Bleeding	Abnormal Clotting	Adopted	Autoimmune Disorders
Brain Tumor	Breast Cancer	Diabetes	Eczema	Endocrine Disease
Heart Disease	Hemophilia	High Blood Pressure	Kidney Disease	Liver Disease
Lung Cancer	Malignant Melanoma	Non-Melanoma Skin Cancer	Other Cancer	Ovarian Cancer
Prostate Cancer	Skin Disease	Von Willebrand		