PATIENT REGISTRATION

Today's Date: _____/_____/_____

Name: _____ Sex: M F Date of Birth:_____ Age:_____

Email: _____

Home Address:_____ Apt # _____

City_____ State_____ Zip_____

Phone number: _____

MEDICAL HISTORY:

Allergies: _____

Medications: _____

Medical Problems: _____

Have you ever taken finasteride (or Propecia) ? □ No □Yes

If Yes, any side effects? _____

Have you ever used topical minoxidil (or Rogaine)? □ No □Yes

If Yes, any side effects? _____

Is your wife currently pregnant, breastfeeding, or planning to get pregnant? □ No □Yes

Do you currently have any newborns, infants, toddlers or kids under age of 5 in the house? □ No □Yes

Do you have any history of depression? □ No □Yes

Do you have a history of the following?

Heart palpitations	□ No	□Yes	Dandruff on scalp?	□ No	□Yes
Low blood pressure	□ No	□Yes	Faintness or dizziness?	□ No	□Yes
Sexual dysfunction	□ No	□Yes	Chest pain?	□ No	□Yes
Decrease libido?	□ No	□Yes	Breast enlargement	□ No	□Yes
Erectile dysfunction	□ No	□Yes			

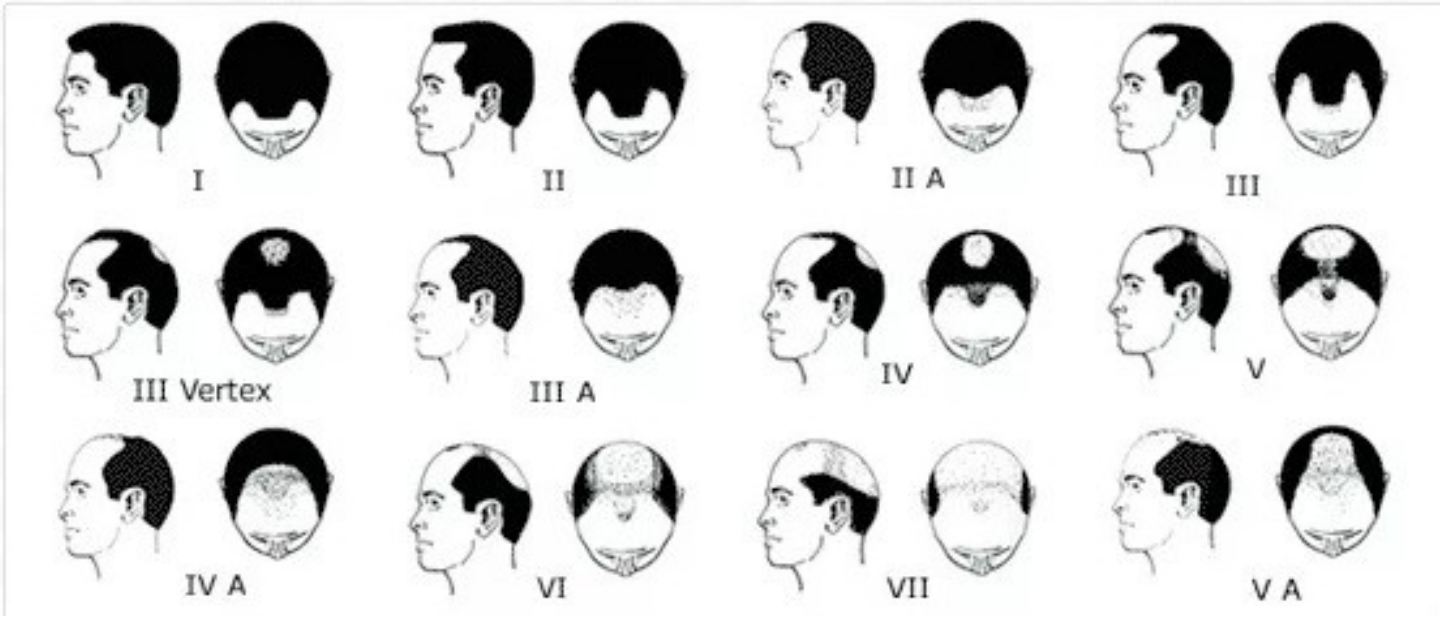
Family history of any skin diseases? □ No □Yes

If YES, please elaborate? _____

Do you have now, or have you ever had diseases or conditions of: (Please check **Yes** or **No**)

Lungs:	**Yes**	**No**	**Other Systemic:**	**Yes**	**No**
Bronchitis/Emphysema	□	□	Diabetes	□	□
Asthma	□	□	Thyroid/Endocrine	□	□
Cough	□	□	Kidney	□	□
			Stomach Ulcer	□	□
			Hepatitis B or C	□	□
Vascular:	**Yes**	**No**	Glaucoma	□	□
Chest Pain	□	□	Arthritis/Joint Deformity	□	□
Heart Attack	□	□	Convulsions, Epilepsy	□	□
Heart Disease	□	□	Fainting	□	□

How do you look like? (please circle one)



MEDICATIONS CONSENT: I voluntarily give my consent to the terms and policy listed on https://santamonicaskin.com and give consent to all the side effects, risks, benefits, advantages, disadvantages of such medications prescribed by Dr,. Behnam, which include but not limited to: avodart, finasteride, minoxidil, retinoic acid, floucinolone, betamethasone, and hydrocortisone. The list of all side effects are listed on our website at https://santamonicaskin.com/side-effects. By using our products, you give your full consent to all the medication benefits, risks and side effects listed on our website. If you do not agree, please do not use our product.

EMAIL, PHONE & TEXT MESSAGE CONSENT: I give permission to Dermatology & Hair Restoration Specialists to contact me via email, phone and text above and **leave a message** on an answering device or with another person who answers the phone to assist office in carrying out appointment reminders, lab results, med. information, treatment, payments, insurance items & operations.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health services we provide you. You may ask to see and copy that records. You may ask to correct that record. You may see your record or get more information about it by contacting this office and asking for Privacy Officer. I understand that, under the Health Insurance portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to perform the following: 1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2. Obtain payment from third party payers. 3. Conduct normal healthcare operations such as quality assessments and physicians certifications. I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *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 restrictions, but if you do agree then you are bound to abide by such restrictions.

By my signature below I acknowledge the receipt of the Notice of Privacy Practices & Agree to all of the above information:

_____ _____

Patient Signature Date