Dale Isaacson, M.D.
Marilyn Berzin, M.D.

PATIENT INFORMATION

******YOU MUST PROVIDE YOUR DRIVERS LICENSE AND CURRENT INSURANCE CARD(S)******

If no insurance information is given you will receive a blank insurance form that YOU will need to fill out for reimbursement from your insurance company

Please take a few minutes to help us update our records:

Date of Birth:_____ Age:_____ Social Security #_____

Name _____
Last First(Proper) Nickname MI

****NAME MUST MATCH HOW IT APPEARS ON YOUR INSURANCE CARD***

Address_____
City State Zip code
Employer_____ Occupation:_____

Home #_____ Work #_____ Cell #_____

Primary Care/Referring Physician: Name_____

Phone#_____

*****APPOINTMENT REMINDERS*****
This must be completed
How would you like to be reminded of your appointment?

Phone number _____and/or

email_____

Please note any changes in your health since your last visit.
Illness: _____

Medications being taken: _____

ALLERGIES:_____

Permission is needed for the following:
Leave DETAILED messages on voice mail or cell phone? ( )Yes ( )No

With whom can we leave information (name and relationship)_____

PROCEDURES/PROMOTIONS/DISCOUNTS
If you like to be updated about procedures/discounts/special events offered in the office please provide your email address:

_____

******WE ONLY PARTICIPATE WITH MEDICARE******
Please provide us with a copy of your CURRENT insurance card.

Primary insurance carrier
Policy Holders Name_____
Policy Holders Employer_____
Policy Holder DOB _____

Secondary insurance carrier
Policy Holders Name _____
Policy Holders Employer_____
Policy Holder DOB _____

What procedures are you interested in learning about?_____

PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE. VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS ACCEPTED. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Drs. Isaacson and Berzin to release such medical information necessary to process your insurance claims (if any). I hereby assign any and all insurance benefits due and payable from my participating insurance company to Drs. Isaacson & Berzin for services rendered. You herein authorize payment of medical benefits to Drs. Isaacson and Berzin when an assigned claim is filed.
I understand that **I personally guarantee to be financially responsible to Drs. Isaacson and Berzin for any and all charges not covered by the assignment of the participating insurance company.**

Signature of Patient/Guardian:_____ Date: _____

Dale H. Isaacson, M.D.
Marilyn Berzin, M.D.
MEDICAL HISTORY

Patient:_____ Date:_____
Reason for today's visit: _____
Are you allergic to any medications? Yes No If yes, list:
1. _____ 2. _____ 3. _____
List all Medications you are currently taking:
1._____ 2._____ 3._____

Have you had any of the following diseases or conditions? (Please check YES or NO)

LUNGS:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
VASCULAR		
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Irregular Heart Beat	❑	❑
Pacemaker	❑	❑
Phlebitis	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Stomach	❑	❑
Bowel	❑	❑
Hepatitis or Yellow Skin	❑	❑
Glaucoma	❑	❑
Arthritis/Joint Deformity	❑	❑
Convulsions, Epilepsy Or Seizures	❑	❑
Fainting	❑	❑

Family History of:		Relation:
Skin Cancer	❑	❑_____
Eczema	❑	❑_____
Psoriasis	❑	❑ _____

Do you drink alcohol? ❑ Yes ❑ No If yes how many drinks per day _____
Do you smoke if yes, how much? ❑ Yes ❑ No _____
Do you bleed easily? ❑ Yes ❑ No
Are you pregnant (women) ❑ Yes ❑ No
Do you use IV drugs? ❑ Yes ❑ No If yes what?_____
Do you have or have you been exposed to HIV (AIDS)? ❑ Yes ❑ No
Have you ever had dental anesthesia (Novocaine). If yes did you have any reactions? ❑ Yes ❑ No
_____
Have you ever had tuberculosis. If yes, when? ❑ Yes ❑ No _____

Skin
When exposed to the sun do you ❑ Tan only ❑ Tan and burn ❑ Burn ❑ Break out in rash?
Have you ever had skin cancer, if yes what kind? ❑ Yes ❑ No _____
Have you ever had X-ray therapy, if yes for what? ❑ Yes ❑ No _____
Do you form keloid scars (excessive scarring or poor healing)? ❑ Yes ❑ No

List any other disease or condition we should know about _____
List any surgical procedures you have had in the past 6 months. If yes what and when: ❑ Yes ❑ No
_____
What is your occupation?_____

Are you interested in learning more about the following procedures? ___Thermage ___Fraxel ___Botox ___
Filters for facial furrows (Sculptra, Restylane, Hylaform, etc) ___ Laser hair removal ___Photorejuvenation (IPL)
___Vetasmooth (for cellulite) ___ Silkpeel/GentleWaves (for skin fitness) ___Therapeutic cosmetics

Patient signature and date_____

DALE H. ISAACSON, M.D.
MARILYN BERZIN, M.D.
1828 L ST. NW #850
WASHINGTON, DC 20036

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Drs. Isaacson & Berzin LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Isaacson & Berzin LLC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Isaacson & Berzin LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Drs. Isaacson & Berzin LLC Privacy Officer at 1828 L St. NW #850, Washington, DC 20036.

With my consent, Drs. Isaacson & Berzin LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Drs. Isaacson & Berzin LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Drs. Isaacson & Berzin LLC may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Isaacson & Berzin LLC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Drs. Isaacson & Berzin LLC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, Drs. Isaacson & Berzin LLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian