

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

PATIENT INFORMATION

*****YOU MUST PROVIDE YOUR DRIVERS LICENSE AND 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: _____

Name _____
Last First(Proper) Nickname MI

Address _____
City State Zip code

Employer _____ Occupation: _____

Home # _____ Work # _____ Cell # _____

Email address: _____ Would you like to be updated about
procedures/discounts/special events offered in this office? ()Yes ()No

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) _____

Primary Care/Referring Physician: Name _____ Phone# _____

Please note any changes in your health since your last visit.

Illness: _____

Medications being taken: _____

ALLERGIES: _____

*****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	Other Systemic:		YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid		<input type="checkbox"/>	<input type="checkbox"/>
Asthma		<input type="checkbox"/>	<input type="checkbox"/>	Kidney			<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		Bladder		<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>		Stomach	<input type="checkbox"/>	<input type="checkbox"/>	
				Bowel		<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR				Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma		<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		Convulsions, Epilepsy			<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>		Or Seizures		<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>		Family History of:		Relation:	
				Skin Cancer		<input type="checkbox"/>	<input type="checkbox"/>
				Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____

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