

JEROME R. POTOZKIN, M.D. & MONICA K. BRAR, M.D.

600 San Ramon Valley Blvd, Suite 102
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925-838-4900
925-838-4920 Fax

PATIENT INFORMATION

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Full Legal Name: _____ Maiden Name: _____
Last First MI

Address: _____
Street City State Zip Code

E-Mail Address: _____ Referred By: _____

Age: _____ Birth Date: _____ Marital Status: _____ Social Security #: _____

Is patient a minor? Yes No Parent/Guardian: _____ Relation: _____

Patient Employed By: _____ Occupation: _____

Employer's Address: _____
Street City State Zip Code

Emergency Contact: _____ Relation to patient: _____ Phone: _____

Person Responsible for Account: _____ Relation to patient: _____

PRIMARY INSURANCE

Insurance Company: _____ Effective Date: _____ Phone: _____

Address: _____
Street City State Zip Code

Subscriber's Name: _____ ID#: _____ Group#: _____

Relation to Patient: _____ Birth Date: _____ Social Security: _____

Subscriber's Employer: _____ Occupation: _____ Phone: _____

Employer's Address: _____
Street City State Zip Code

SECONDARY INSURANCE

Insurance Company: _____ Effective Date: _____ Phone: _____

Address: _____
Street City State Zip Code

Subscriber's Name: _____ ID#: _____ Group#: _____

Relation to Patient: _____ Birth Date: _____ Social Security: _____

Subscriber's Employer: _____ Occupation: _____ Phone: _____

Employer's Address: _____
Street City State Zip Code

PATIENT SIGNATURE

I, certify that I (or my dependent) have insurance coverage with _____ Insurance Company and assign insurance benefits directly to Dr. Potozkin, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature

Relationship

Date

↓ For Staff Use Only ↓

Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____

Male

Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____

Female

Jerome R. Potozkin, M.D., P.C.

MEDICAL HISTORY

To help evaluate your present, past and future health concerns. PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM.

Name _____ Date _____

Age: _____ Sex: M F Referred By: _____

Reason for today's visit: _____ Skin Cancer Monitoring CC

Symptoms of today's problem: _____ HPI

Skin areas involved: _____ LOCATION

How long has the problem been present? _____ DURATION

Was there any previous treatment? Yes No When? _____ Type? _____ TIMING

Was a biopsy done? No Yes biopsy done by referring Dr. Other _____ CONTEXT

CHECK ALL THAT APPLY TO TODAY'S PROBLEM

QUALITY

A change in:

- size
 color
 elevation
 hardness
 other
 none

MODIFYING FACTORS

A history of:

- X-ray treatments (not routine dental or chest x-rays)
 UV light treatments
 arsenic exp/treatments
 chronic scar
 immunosuppression
 none

ASSOCIATED SYMPTOMS

- bleeding
 tingling
 pain
 ulceration
 infection
 itching
 other
 none

SEVERITY

- no symptoms
 occasional symptoms
 constant symptoms

SYSTEM REVIEW: Check all that apply regarding your health and add any other important problems.

Allergies to Medication: none list: _____

Current Medications: _____

Skin

- abnormal scarring
 poor healing
 other skin disorders

Hematologic/Lymphatic

- normal
 anemia
 bleeding problems
 enlarged lymph nodes

Constitutional Symptoms

- none
 weight loss
 fever
 other:

Eyes/Ears/Nose/Throat

- normal
 glaucoma
 hearing aid
 plastic surgery

Cardiovascular

- normal
 angina
 artificial heart valve
 pacemaker
 hypertension
 heart attack (when?)

Respiratory

- normal
 asthma
 emphysema
 other lung problems

Gastrointestinal

- normal
 stomach ulcer
 colitis
 liver damage
 other GI problems:

Musculoskeletal

- normal
 arthritis
 artificial joint
 other:

Neurological

- normal
 stroke
 seizures
 other:

Psychiatric

- normal
 depression
 anxiety attacks
 other:

Endocrine

- normal
 diabetes
 thyroid
 kidney disease

Infections

- none
 hepatitis
 HIV/AIDS
 tuberculosis (T.B.)
 other:

PAST HISTORY Previous Skin Cancer: none list location(s): _____

Major illnesses or Hospitalizations: _____

FAMILY HISTORY Skin Cancer: none melanoma basal cell squamous cell List: _____

SOCIAL HISTORY Occupation: _____ Marital Status: Single Married Divorced Widow

Previous sunlight exposure or sunburns: mild moderate extensive tanning bed use Do you wear?: dentures glasses contact lenses

Do you Smoke?: no former yes, packs per day Alcohol: no social/occasional drinking only

Alcohol or drug problems/addictions: no yes, describe: _____

Reviewed: _____

NEW PATIENT HISTORY FORM:

NAME: _____ (DoB: ___-___-19___) **DATE:** ___-___-20___
 Who can we thank for referring you? _____

REASON for visit: **SPIDER VEINS** for ___ years **VARICOSE VEINS** for ___ years

1. Do you experience any of the following **SYMPTOMS?** **RIGHT LEG** **LEFT LEG**

IF YOU HAVE **NO**
SYMPTOMS,
PLEASE GO TO # 2.
↓

- | | | |
|------------------------------|--------------------------|--------------------------|
| Aching or pain along a vein? | <input type="checkbox"/> | <input type="checkbox"/> |
| Heaviness? | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg tiredness or fatigue? | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen ankles or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| Restless legs? | <input type="checkbox"/> | <input type="checkbox"/> |
| Itching? | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning? | <input type="checkbox"/> | <input type="checkbox"/> |

Other? _____

- ◆ How **LONG** have you experienced the above mentioned symptoms? _____
- ◆ How **OFTEN** do you experience these symptoms? daily weekly monthly
 other: _____

- ◆ Which of the following **IMPROVES** your symptoms?

	<u>HELPS</u>	<u>DOESN'T HELP</u>	<u>HAVEN'T TRIED</u>
Elevating legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rx Compression stockings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTC pain meds (advil, Tylenol, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			

- ◆ Which of the following **WORSENS** your symptoms?

	<u>WORSE</u>	<u>NO CHANGE</u>	<u>N/A</u>
Prolonged standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			

- ◆ How many **hours** a day do you spend **sitting or standing?** _____

- 2. Have your legs gotten significantly **worse** in the last few **months?** no yes
- 3. Have you had leg vein **TREATMENT in the PAST?** no yes → please answer the following:
 When? _____ By whom? _____
 Was an ultrasound done of your legs before treatment? no yes ?
 What treatment(s) were done? injections laser stripping can't remember
 Did you wear graduated compression stockings after treatment? no yes
 What was your result? _____

- 4. Have you had any **MAJOR INJURIES** to either leg? no yes: _____
 Have your legs ever been in a cast? no yes → right left

5. **FEMALES ONLY:**

- ◆ **Obstetric history:** Number of pregnancies: ___ Number of children: ___ (please list ages: _____)
 Number of miscarriages: ___ Are you now (or in the next 6 months) trying to conceive? no yes
- ◆ Do you use **birth control?** no yes → method: the pill other: _____
- ◆ Are you **menopausal:** no yes → are you currently using **estrogen** replacement? no yes

Date of last pap smear: _____ Date of last mammogram: _____

Reviewed: _____
 Monica Brar, M.D.

EAST BAY VEIN CENTER ◆ 600 San Ramon Valley Blvd, Suite # 102, Danville, CA, 94526 ◆ phone 925.838.4900 ◆ fax 925.838.4920

6. PERSONAL MEDICAL HISTORY: Please check all that apply to you:

Patient Name: _____
 Primary Care MD: _____

CARDIOVASCULAR:

- normal
- high blood pressure
- high cholesterol
- heart disease
- mitral valve prolapse
- heart attack history
- _____

ENDOCRINE:

- normal
- diabetes, type _____
- thyroid problems
- _____

HEMATOLOGIC/LYMPHATIC:

- normal
- coagulopathy** (clotting disorder making blood too thick and prone to clotting): Type: _____
- deep vein thrombosis** (aka: DVT, or a blood clot in a deep vein in the leg): When? _____ Which leg? right left
 Treatment given? _____ How long were you treated? _____
- pulmonary embolism** (aka: PE, or a clot that has traveled to the lungs): When? _____ How long were you treated? _____
- phlebitis** (inflammation of a varicose vein with pain, redness, hard lump): When? _____ Which leg? right left
- anemia
- _____

◆ **PERSONAL CANCER HISTORY?** no yes: (when and type): _____

◆ **OTHER MEDICAL PROBLEMS NOT LISTED ABOVE:** _____

NEUROLOGIC:

- normal
- migraines
- stroke
- seizures
- _____

PSYCHIATRIC:

- normal
- anxiety/panic attacks
- depression
- _____

RESPIRATORY:

- normal
- asthma
- _____

**RHEUMATOLOGIC/
MUSCULOSKELETAL:**

- normal
- arthritis
- lupus
- fibromyalgia
- osteopenia/porosis
- muscular problems
- _____

GASTROINTESTINAL:

- normal
- irritable bowel syndrome
- GERD (reflux/heartburn)
- colitis
- ulcers
- liver disease
- _____

GYN / UROLOGIC:

- normal
- menstrual problems
- breast problems
- bladder problems
- kidney problems
- _____

7. PERSONAL SURGICAL HISTORY: Please list all past surgeries with approximate date:

1. _____
2. _____
3. _____
4. _____

8. SOCIAL HISTORY: married single divorced widow or widower

- ◆ **Occupation:** _____ for _____ years
- ◆ **Cigarette smoking:** no yes: _____ packs per day for _____ years
- ◆ **Alcohol consumption:** never <=1 drink/month ___ drinks every ___ day(s)
- ◆ **Recreational drug use:** no yes: _____
- ◆ **Exercise:** not at all 1 to 3 times/week 4 to 6 times/week daily
 What type of exercise do you do? _____

9. DRUG ALLERGIES: none latex yes, allergies → please list below with type of allergic reaction:

1. _____
2. _____
3. _____

10. CURRENT MEDICATIONS: Please list below with dosages if possible:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

11. FAMILY HISTORY: unknown List your **siblings** also please:

	Alive	Deceased	Age	spider veins?	Varicose veins?	Clot in leg or lungs?	Clotting disorder?
◆ Mother:	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ Father:	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reviewed:

 Monica Brar, M.D.

JEROME P. POTOZKIN, M.D. & MONICA K. BRAR, M.D.

6000h Ramon Valley Blvd. #102, Danville, CA 94526

TEL (925) 838-4900 FAX (925) 838-4920

I hereby authorize Dr. Potozkin / Dr. Brar to use and disclose my individually identifiable health information ("Health Information") in the manner described below. I understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

Messages may be left on my cell phone for the following types of appointments: Medical Cosmetic

Messages may be left on my home answering machine for the following types of appointments: Medical Cosmetic

Detailed messages regarding test results (or) advice may be left on my home answering machine: Yes No

Detailed messages regarding test results (or) advice may be left on my work voice mail: Yes No

Detailed messages regarding test results (or) advice may be left on my cell phone: Yes No

Medical Information can be discussed with: Patient Only Family Member Friend

Name: _____ Relationship: _____ Phone: _____

Medical Information can be released or faxed to my: Physician Insurance Company Pharmacy

Name: _____ Phone: _____

Account/Billing Information can be released to: Patient Only Family Member Friend Other

Name: _____ Relationship: _____ Phone: _____

I have an advance health care directive: Yes No

In the event you are not able to speak, an Advance Health Care Directive, a legal document states your health care treatment plan and allows an appointed person to represent you.

I give Dr. Potozkin / Dr. Brar permission to send a thank you letter to the person who referred me: Yes No

I give Dr. Potozkin / Dr. Brar permission to communicate with me via email: Yes No

_____ I understand that I am financially responsible for all cosmetic charges at the time of service.

_____ I understand that I am financially responsible for all medical charges whether or not paid by health insurance.

_____ I understand that I am responsible for understanding my medical insurance benefits and coverage.

_____ I understand that I am responsible for obtaining all authorization for follow-up visits.

_____ I understand my medical insurance may not pay for routine labs (or) pathology tests (including biopsies).

_____ By signing, I authorize Dr. Potozkin's billing service (Aesyntix Billing Solutions) to submit medical claims to my insurance plan(s).

_____ I authorize Dr. Potozkin's office to act as my agent in helping me obtain payment from my insurance company.

_____ I authorize payment directly to Dr. Potozkin's office.

_____ I have been given a brochure of the **Notice of Privacy Practices**, a federal privacy law created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA), (effective April 14, 2003).

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If not signed by patient, please indicate relationship: Parent, if patient is under 18 yrs of age Guardian, if patient is under 18 yrs of age
 Guardian or conservator of an incompetent patient Beneficiary or personal representative of deceased patient

Jerome R. Potozkin, M.D.

Cosmetic Interest Questionnaire

Patient Name:		Date:	
What is the reason for your visit today?			
Other than the services we have provided for you, what additional services would you like to learn about? (Please check all that apply)			
<input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> BOTOX®/Dysport® <input type="checkbox"/> Restylane®/Juvederm® <input type="checkbox"/> Facial lines/wrinkles <input type="checkbox"/> Thin lips <input type="checkbox"/> Blotchy skin <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Brown spots/freckles <input type="checkbox"/> Drooping brow <input type="checkbox"/> Drooping eyelids <input type="checkbox"/> Nose shape <input type="checkbox"/> Facial fullness <input type="checkbox"/> Mole removal <input type="checkbox"/> Scar revision	<input type="checkbox"/> Neck wrinkles <input type="checkbox"/> Abdominal area <input type="checkbox"/> Hips <input type="checkbox"/> Acne scarring <input type="checkbox"/> Liposculpture <input type="checkbox"/> Laser hair removal <input type="checkbox"/> Tattoo removal <input type="checkbox"/> Length/fullness of eyelashes <input type="checkbox"/> Leg veins	
What cosmetic procedures, if any, have you had in the past?			
If you have previously had any cosmetic procedures, were you pleased with the outcome?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If our office hosted an event to inform patients about cosmetic procedures or products, would you be interested in attending?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			

Thank you for your time