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

600 San Ramon Valley Blvd, Suite 102
Danville, CA 94526
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

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

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION / SIGNATURE ON FILE
6 Year Consent Form (must be updated if patient is not seen in a 2-year period)

I hereby authorize Dr. Potozkin / Dr. Brar to use and disclose my individually identifiable protected health information ("PHI") 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 / home phone 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

Physician's 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 *We do not honor advanced directives.*

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

PLEASE READ AND INITIAL

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

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

_____ By signing, I authorize Dr. Potozkin's / Dr. Brar's office to mail to my home any items that assist the practice, such as appointment reminder cards and statements, as long as they are marked *Personal and Confidential.*

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

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

_____ I have been given the **Notice of Privacy Practices**, a federal privacy law created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA), (Revised 9/23/13).

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

We have a rule in our practice; it's called the "No Jerks Rule". You might have a similar rule in your dealings (we hope so!). Life is too short to work with people who treat you poorly. We only serve patients who are polite, professional and respectful. You can expect us to treat you with dignity and respect at all times. We expect the same, no exceptions.

Potozkin MD SkinCare & Laser Center, Inc.

600 San Ramon Valley Blvd, Suite 102
Danville, CA 94526
P: 925.838.4900
F: 925.838.4920

What are your reasons for visiting Potozkin MD SkinCare & Laser Center? (circle all the apply)

Botox/Dysport/Xeomin Dermal Filler	Acne	Acne Scarring
CoolSculpting/Lipo	Leg Veins	Skin Tightening
Laser Treatments	Kybella	Skincare
Mole Removal	Tattoo Removal	Hydrafacial/Chemical Peel
Fine Lines/Wrinkles	Hyperpigmentation	Eyelid Surgery
Facial Redness/Spots	Thin Lips	Medical Condition

Current Medications:

_____

_____

Allergies:

_____

_____

Medical History (circle all the apply)

Diabetes	Cancer	Arthritis	Sezures/Epilepsy
Autoimmune Disorder	Hepatitis	Active Skin Infection	HIV/AIDS
Bleeding Disorder	Anxiety	Depression	
High Blood Pressure	GastroIntestinal	Psoriasis	Vitiligo
Poor Wound Healing	Claustrophobic	Hyperthyroidism	Tattoos
Multiple Sclerosis ALS	Heart Condition/Pacemaker	Stroke	Eyes/Ears/Nose/Throat
Bell's Palsy Cold Sores/Fever Blisters	Asthma	Endocrin Condition	Musculoskeletal

Skin Procedure History

Have you ever had any of the following treatments before? (circle all that apply)

Microdermabrasion	Liposuction	Waxing
HydraFacial	Chemical Peels	Botox Injections
Laser Resurfacing	Dermal Fillers	Phototherapy
Laser Hair Removal	PRP	Facelift
Blepharoplasty for eyelid	Facial Treatment	Skin Cancer Surgery

Have you seen a dermatologist for your current skincare complaints? If so, whom and explain

_____

_____

_____

Personal Skin Care Assessment

What is your race/ethnicity? _____

Which of the following best describes your skin when exposed to the sun for 30 minutes without SPF (Fitzpatrick scale)?

___Always burns easily, never tans with very pale skin tone

___Always burns, tans with a hint of color with very pale skin tone

___Burns initially, tans gradually with light skin tone

___Can burn and can tan with olive/gold skin tone

___Rarely burns and brown skin tone

___Rarely burns with very deeply pigmented skin tone

How would you describe your skin? Please check the one you think applies at this moment.

___Oily- large pores, always oily/shiny

___Combo oily- medium pores, oily T-zone, oil with dry perimeter

___Dry- small pores, flaky, tight, shallow skin

___Sensitive- frequent redness, sun sensitive, product sensitive

___Mature skin- loss of elasticity, hormonally dry/oily variance, fine lines & wrinkles

Please circle the components of your daily skin regimen

Cleanser

Day Cream

Eye Cream

Night Cream

Toner

Sunscreen

Exfoliation

Other

Hormone Assessment

Are you pregnant? Y or N

Did you recently give birth? Y or N

Are you currently breastfeeding? Y or N

Are you taking fertility medications? Y or N

Are you undergoing hormone replacement therapy? Y or N

Has a doctor ever prescribed Accutane, Retin-A, Renova or antibiotics for acne? Y or N

Are you currently taking acne or skin medications? Y or N

Please list them: _____

General Considerations

Do you bruise easily? Y or N

Do you scar easily? Y or N

Do you smoke? Y or N

If yes, how much? _____

Do you drink alcohol? Y or N

If yes, How much? _____

Do you use self-tanners (creams or spray-on) or visit a tanning booth? Y or N

If yes, how often? _____ When was your last visit? _____

Additional information

Please let us know anything else you would like to discuss with us during your visit today.

_____

_____

Consent to Share Photographs

Patients often find that viewing before and after pictures can be helpful when deciding about having surgery or a particular treatment. To this end, we ask our patients to consider sharing their photos as a way of helping others. Thank you for your consideration. Please indicate your preferences by initialing all that apply.

Use of Patient Photographs

I give consent to Jerome R. Potozkin, M.D., P.C. to use my photographs for the following purposes:

____Sharing with other Doctors & Professionals for advisement regarding services

____Marketing for **PotozkinMD SkinCare & Laser Center Inc.** (e.g. websites)

____Staff educational purposes (e.g. internal office conferences, meetings, presentations) ____Patient educational purposes outside our office (e.g. community seminars or meetings)

____Patient educational purposes in our office (e.g. patients considering a similar surgery,

procedure or treatment)

____ I DO NOT give consent to **PotozkinMD SkinCare & Laser Center, Inc.** to utilize my photographs for any reason

I understand, have read and completed this questionnaire entirely and truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from your treatment that may be irreversible.

Patient signature _____ **Date**_____