JEROME R. POTOZKIN, M.D. | MONICA K. BRAR, M.D. | SAMANTHA ELLIS, M.D.
600 San Ramon Valley Blvd. #102, Danville, CA 94526
TEL (925) 838-4900 FAX (925) 838-4920

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: _____

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

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Decline to State
Race: ☐ White ☐ Asian ☐ African American ☐ Other ☐ Decline to State
Language: ☐ English ☐ Other: _____

Age: _____ Birth Date: _____ Marital Status: _____

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

(If yes, complete guarantor information below)

Guarantor: _____ Birth Date: _____

Emergency Contact: _____ Relation to Patient: _____ Phone: _____

PRIMARY INSURANCE

Insurance Company: _____ Effective Date: _____ Phone: _____

Address: _____
Street City State Zip Code

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

Relation to Patient: _____ Birth Date: _____

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: _____

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

POTOZKIN MD
SKINCARE CENTER

Skin problem(s) today: _____

_____

Do you have, or have you been treated for (circle yes or no)?

Diabetes	YES	NO
Asthma	YES	NO
Seasonal Allergies	YES	NO
Tuberculosis	YES	NO
Hepatitis	YES	NO
HIV	YES	NO
Cold sores	YES	NO

Inflammatory Bowel Disease	YES	NO
Organ Transplant	YES	NO

Skin cancer:

• Basal Cell	YES	NO
• Squamous Cell	YES	NO
• Melanoma	YES	NO

Pacemaker	YES	NO
Artificial Heart Valve	YES	NO

Women only:

• Are you pregnant?	YES	NO
• Are you breastfeeding?	YES	NO
• Plan for pregnancy within 12 months?	YES	NO

Have you had any other medical problems? _____

_____

Medications? _____

_____

Allergies to medications (please list): _____

Are you allergic to:

Tape?	YES	NO

Neosporin?	YES	NO

Bacitracin?	YES	NO

Has any member of your immediate family (i.e. parent, sibling, or child) ever had?

Melanoma skin cancer	YES	NO
Asthma or hay fever	YES	NO

Eczema	YES	NO
Psoriasis	YES	NO

Lupus	YES	NO
Other autoimmune disease	YES	NO

Social History:

Do you smoke tobacco or use other tobacco products?	YES	NO
Have you ever smoked tobacco or used other tobacco products?	YES	NO
Have you used tanning beds?	YES	NO

Alcohol Use:	YES	NO
Drinks per week (glasses of wine, beers, mixed drinks) _____		
Daily use of sunscreen?	YES	NO

Review of Systems || Have you had any new/recent (circle yes or no)?

Persistent fevers	YES	NO
Unintentional weight loss	YES	NO

Abdominal pain	YES	NO
Headaches	YES	NO

Persistent Cough	YES	NO
Joint pain	YES	NO

Cosmetic assessment: (This section is *optional*. However, please complete if you are here for a cosmetic consultation.)

Have you previously had (circle YES or NO)?

Botox (or other neurotoxin) injections (YES, NO): If YES, what locations (on face): _____

Filler (ex. Juvederm, Restylane) injections (YES, NO): If YES, what locations: _____

Laser or light treatments (ex. Fraxel, IPL) (YES, NO): If YES, which device and dates: _____

Head or neck surgery (ex. Rhinoplasty, eyelid surgery), please list with dates: _____

Other cosmetic procedures (YES, NO): _____

Do you currently use?

Daily topical antioxidant (ex. Vitamin C serum)	YES	NO
Daily topical retinoid (ex. Renova, retinol, tretinoin)	YES	NO

Daily sunscreen (SPF 30 or higher)	YES	NO
Daily facial moisturizer	YES	NO

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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 / Dr. Ellis 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 / Dr. Ellis permission to send a thank you letter to the person who referred me: ☐Yes ☐No

I heard about this practice through: _____

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 / Dr. Ellis'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 / Dr. Ellis'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 / Dr. Ellis'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 / Dr. Ellis'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.