DALE ISAACSON, MD
MARILYN BERZIN, MD

Name: _____
(Name must match that on your insurance card)

Date of Birth: _____ Age: ___ Gender: ___ Email: _____
Address: _____
(Street) (City) (State) (Zip)
Mobile: _____ Home: _____ Work: _____
(Mobile needed for appt reminder)
Height: _____ Weight:_____ BMI_____(staff only)
(Required fields for prescriptions)
Okay to leave a detailed voice message: (Select one) Mobile Home Work

Someone else? Please provide name and phone: _____
Would you like to receive email updates regarding special promotions? Yes No

Primary Care Provider Name: _____ Phone: _____

Billing: Please bring a photo ID and your insurance card at the time of your visit. We will require both

Our Providers participate with Medicare ONLY
Policy Holder Name: _____DOB: _____ Relationship:_____
Policy Number: _____ Group #_____

(Secondary insurance if applicable)
Policy Holder Name:_____ DOB: _____ Relationship _____
Policy Number: _____ Group #_____

Payment is expected at the time of service. We accept Visa, MasterCard, Discover, American Express, Cash.

My signature below indicates I understand and accept these policies. Further, my signature authorizes Drs. Isaacson & Berzin to release such medical information necessary to process insurance claims, if any.

I hereby assign all insurance benefits due and payable from my insurance company to Drs. Isaacson & Berzin for all charges NOT covered by the assignment of the insurance company.

I understand that I personally guarantee to be financially responsible to Drs. Isaacson & Berzin for all charges not covered by the assignment of the insurance company.

Signature of patient/guardian: _____ Date: _____

Cosmetic Appointments

We value your trust in our caring for your appearance!
To provide the best service for all our valued clients, we request consideration of the following:

- $ Cosmetic treatment(s) is/are NOT covered by insurance; you will be responsible for payment in full at time of appointment
- $ We require a deposit of $150.00 for ALL cosmetic procedures.(unless otherwise specified)
- $ If you arrive late for your appointment, we may not be able to offer you the full time allotted and/or will be rescheduled.
- $ Contact us at least 24 hours in advance to reschedule/cancel, to avoid a cancellation fee of $150.

My signature confirms that I have read and accept this policy.
Signature of patient/guardian: _____ Date: _____

Medical information update form

We ask you to fill out the form completely

Name: _____ **Date of birth**: _____

Allergy to medication(s)

_____

_____

All current medication(s) Include: dose for dermatology meds, other meds, IUD or implanted drug reservoir

_____

_____

Pharmacy Name and location:_____ **Phone:**_____

Do you have a pacemaker? Yes No

Do you smoke tobacco? Yes No If yes, how much _____

Do you drink alcohol? Yes No If yes, how many _____

Female patients only: I am/may be pregnant? YES NO

Breastfeeding? YES NO

Prior skin history and family skin history

	SELF		FAMILY		Comments or details
Melanoma	**Yes**	**No**	**Yes**	**No**	
Non-Melanoma skin cancer	**Yes**	**No**	**Yes**	**No**	
Eczema, asthma, hay fever	**Yes**	**No**	**Yes**	**No**	
Psoriasis	**Yes**	**No**	**Yes**	**No**	
Keloids (large scars)	**Yes**	**No**	**Yes**	**No**	
Other skin disorders	**Yes**	**No**	**Yes**	**No**	
Arthritis	**Yes**	**No**	**Yes**	**No**	
Autoimmune disease	**Yes**	**No**	**Yes**	**No**	
Bleeding disorder	**Yes**	**No**			
Depression/Bi-Polar	**Yes**	**No**			
Diabetes	**Yes**	**No**			
Facial implants	**Yes**	**No**			
Cancer (other than skin)	**Yes**	**No**			
Cold sores	**Yes**	**No**			
Glaucoma	**Yes**	**No**			
Heart or kidney transplant	**Yes**	**No**			
Heart valve disease/murmur	**Yes**	**No**			
High blood pressure	**Yes**	**No**			
HIV/AIDS	**Yes**	**No**			
Kidney disease	**Yes**	**No**			
Liver disease/hepatitis	**Yes**	**No**			
Pacemaker/Defibrillator	**Yes**	**No**			
Blood clots	**Yes**	**No**			
Thyroid disease	**Yes**	**No**	**Yes**	**No**	
Tuberculosis	**Yes**	**No**			
Other – please detail	**Yes**	**No**			

Signature of patient/guardian: _____ **Date:** _____

DC DERM DOCS
COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that all the staff at Drs. Isaacson & Berzin PLLC/DC Derm Docs, are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for all the staff at Drs. Isaacson & Berzin PLLC/DC Derm Docs to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery. I

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

08/04/2020

_____

Patient/Guardian Date