Alam Leah Berke M.D., F.A.A.D.

Board Certified Dermatologist and Dermatologic Surgeon

PERSONAL INFORMATION

Patient Name: _____ Parent/Guardian:_____
If patient is a Minor

Address: _____ City:_____ State_____ Zip_____

DOB:_____ SSN#:_____ - _____ - _____

Home#: (_____)_____-_____ Work#: (_____)_____-_____ Cell#: (_____)_____-_____

*Please Provide Us With Your Email: _____

Marital Status: *Circle One Single Married Divorced Widowed Committed

Occupation:_____ Employer:_____

Primary Physician (PCP):_____ PCP Phone: (_____)_____-_____

Emergency Contact: _____ Contact Phone: (_____)_____-_____

HEALTH INSURANCE INFO

Primary Insurance:_____ Secondary Insurance:_____

Policyholder Name: _____ Policyholder Name: _____

Relationship to Insured: □Self □Parent □Spouse □Other_____ Relationship to Insured: □Self □Parent □Spouse □Other_____

Has Your Deductible Been Met? □ YES □ NO Has Your Deductible Been Met? □ YES □ NO

Who may we thank for referring you? _____

PLEASE READ & SIGN BELOW **OFFICE FINANCIAL POLICY** **PLEASE READ & SIGN BELOW**

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for ALL services at the time the are rendered unless you are in an insurance with whom we are contracted. For those patients, applicable co-payments and deductibles will be collected on the day of your office visit. We accept payment in the form of cash or credit card ONLY.

If your account had an unpaid balance by your insurance company, payment is due upon receipt of a statement from our office. Payments not received within 10 working days will be turned over to a collections agency and you will be responsible for the outstanding balance and the collection agency fees associated with the collections process. Your signature below signifies that you fully understand and are willing to comply with this said policy.

Patient/Guardian Signature: _____ Date: _____

Print Patient/Guardian Name: _____

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CANCELLATION, RESCHEDULING, AND NO-SHOWs POLICIES

It is our desire to provide each patient with the highest quality service provided in the most expeditious manner. Therefore, we provide a reserved slot for each patient with a need in order to minimize waiting times and maximize continuity in treatment.

In order to provide this service, we ask that you call 24 hours in advances if you are unable to keep your scheduled appointment. In the event that a patient demonstrates disregard for this policy, a $25.00 charge per no show and/or cancelled/rescheduled appointments at last minute will be assessed.

We appreciate the opportunity to serve you and will constantly striving to improve our services to you, our patient!

Thank you for your consideration,

_____

Patient Signature

1400 N.E. Miami Gardens Drive, Suite 202 North Miami Beach, FL 33179

Tel: 305 – 940 – 7546 Fax: 305 – 940 - 4611

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PERMISSION TO DISCUSS YOUR HEALTH INFORMATION WITH OTHER INDIVIDUALS

Patient Name: _____ Date of Birth:_____

Please list the names of the individuals with whom we may discuss your private health information:

	Name	Relationship to Patient
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

By signing this form, I hereby grant permission to Dr. Alam L. Berke, M.D. and her staff to discuss information related to my care with the individuals I listed above.

Signature: _____

***Patients that are 18 years of age or older must sign this form. The signature of a spouse or parent/guardian is not valid (Parent/guardian only valid when Patient is under 18 years of age)

Relationship to Patient: _____ Date: _____

PLEASE FILL OUT BOTH PAGES COMPLETELY

Patient Name _____ Age: _____ Date: _____
Reason for today's visit _____
Where is the problem located? _____ When did it start? _____
What symptoms are you having? _____ Severity: ☐ Mild ☐ Moderate ☐ Severe
What makes condition better or worse? _____
What medications have you used? _____
Please list all the Prescription and Non prescription Medications that you are currently taking:

☐ NONE

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies to medicines? Y N If Yes, Please list:

PAST MEDICAL HISTORY: ☐ NONE. I Am Healthy

☐ Psoriasis ☐ Ezcema/Dermatitis ☐ Acne ☐ Skin Cancer: **Where and What type?** _____

☐ Other Skin Problem: _____

Lungs

☐ Bronchitis ☐ Emphysema ☐ Asthma ☐ Chronic Cough ☐ Morning Cough

Vascular

☐ High Blood Pressure ☐ Chest Pain ☐ Heart Attack ☐ Irregular Heartbeat ☐ Blood thinners

☐ Pacemaker ☐ Blood Clots/Phlebitis ☐ Bleeding problem ☐ Heart Murmur

Other Systemic

☐ Diabetes ☐ Thyroid ☐ Kidney ☐ Bladder ☐ Stomach

☐ Bowel ☐ Hepatitis B or C ☐ Glaucoma ☐ Arthritis/Joint ☐ HIV

Do you have artificial joints? Y N If yes, please list _____
Other Medical Problems that we should be aware of? _____

FAMILY HISTORY:

Are there any diseases that run in your family? Y N If yes, please list _____

Please answer the following questions

Do you take antibiotics for dental procedures? Y N If yes, why? _____
Do you drink alcohol? Y N If yes, how much? _____
Do you smoke? Y N Packs per day_____
Are you allergic to local anesthesia? Y N
Are you latex intolerant or allergic? Y N Please let staff know if you are latex allergic
Is there anything else that we should be aware of? Y N _____

Women Only

Are you pregnant? Y N
Are you trying to become pregnant? Y N
Are you breast feeding? Y N

Women: If you answered yes to these questions, please let Dr. Berke and the staff know! Thank you

Review of Systems:
Are you currently having trouble with any of the following organ systems:
If Yes, Please describe:

Eyes	□ Yes □ No	_____
Ears/ Nose/ Throat/ Mouth	□ Yes □ No	_____
Heart	□ Yes □ No	_____
Lungs	□ Yes □ No	_____
Stomach/ Bowel	□ Yes □ No	_____
Kidneys	□ Yes □ No	_____
Arthritis/ Muscles/ Joints	□ Yes □ No	_____
Headaches/ Seizures	□ Yes □ No	_____
Psychological disorder	□ Yes □ No	_____
Endocrine/ Hormonal	□ Yes □ No	_____
Fever/ Chills	□ Yes □ No	_____

Patient Signature: _____ _____ DATE_____
Reviewed by Dr. Berke

WE OFFER A FULL RANGE OF COSMETIC PROCEDURES
THESE PROCEDURES ARE NOT COVERED BY INSURANCE

PLEASE CIRCLE ANY OF THE FOLLOWING PROCEDURES THAT YOU WOULD LIKE TO DISCUSS WITH DR. BERKE

BOTOX

SCLEROTHERAPY FOR LEG VEINS

LIP AUGMENTATION

RESTYLANE or RADIESSSE FILLER FOR WRINKLES

KERATOTOIC GROWTH REMOVAL

FACIALS FOR MEN AND WOMEN
Deep Pore Cleansing Facial

EARLOBE REPAIR

SKIN TAG REMOVAL

AGE (BROWN) SPOTS ON HANDS, ARMS, CHEST

CHEMICAL PEELS FOR SKIN PIGMENTATION/ MELASMA

ANTI AGING SKIN CARE PRODUCTS