



**La Face by Laura Phan, MD, Inc**  
**MEDICAL HISTORY QUESTIONNAIRE**

**PLEASE PRINT**

**Today's Date** \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Sex: M F** **Age** \_\_\_\_\_

**Reason for your visit today (Please describe the details of your problem)** \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** Have you **ever** had any of the following conditions? If YES, please elaborate if applicable.

Anemia	NO YES: _____	Hepatitis	NO YES: _____
Arthritis (other than back)	NO YES: _____	HIV/AIDS	NO YES: _____
Bleeding disorders	NO YES: _____	Hypertension	NO YES: _____
Cancer	NO YES: _____	Immune disease	NO YES: _____
Diabetes	NO YES: _____	Sinus disease	NO YES: _____
Fever blisters/ Cold Sores	NO YES: _____	Sleep apnea	NO YES: _____
Graves/Thyroid disease	NO YES: _____	Transfusion	NO YES: _____
Heart attack or stroke	NO YES: _____	Tuberculosis	NO YES: _____

**PERSONAL OCULAR HISTORY:** Have you **ever** had any of the following conditions? If YES, please elaborate if applicable.

Cataract	NO YES: _____	Thyroid eye disease	NO YES: _____
Dry eyes	NO YES: _____	Trauma to eye	NO YES: _____
Glaucoma	NO YES: _____	Vision loss not correctable	NO YES: _____
Retinal diseases	NO YES: _____	Watery eyes	NO YES: _____

**OPERATIONS** (Include eye surgery)

**Year**

**SOCIAL HISTORY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Live alone: NO YES

Occupation: \_\_\_\_\_

Smoking: \_\_\_\_\_ packs per day since \_\_\_\_\_

Year quit: \_\_\_\_\_

Alcohol: \_\_\_\_\_ drinks per day

Illicit drugs: \_\_\_\_\_

After surgery/injury, do you develop: pigmented scars, large or thick scars, or other abnormal scars. Circle all that applies.

**ALLERGIES:**

Allergic to Latex: NO YES

Medication Allergies: NO YES If YES, please list below and specify reaction

**Medication Allergies:** \_\_\_\_\_

**CURRENT MEDICATIONS** (Include eye medication, aspirin, advil, ibuprofen, naproxyn, other non-steroidal anti-inflammatory drug, vitamin, and nutritional supplement)

**Name**

**Dose**

**Frequency**

**Reason**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY** (please indicate relation, i.e., father, mother, grandfather, grandmother, siblings, children)

Cancer \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Heart attack \_\_\_\_\_  
Stroke \_\_\_\_\_  
Thyroid \_\_\_\_\_

Glaucoma \_\_\_\_\_  
Macular degeneration \_\_\_\_\_  
Retinal detachment \_\_\_\_\_  
Droopy lids \_\_\_\_\_  
Other inherited eye condition \_\_\_\_\_

Other (specify) \_\_\_\_\_

**REVIEW OF HEALTH SYSTEMS:** Please indicate any problems you have had in the **past six months**. If YES, please elaborate.

**CONSTITUTIONAL:**

Weight gain or loss-more than 10 lbs. NO YES: \_\_\_\_\_  
Marked fatigue NO YES: \_\_\_\_\_  
Unexplained night fever/sweats NO YES: \_\_\_\_\_  
Migraine headaches NO YES: \_\_\_\_\_

**EARS/NOSE/MOUTH/THROAT:**

Hearing loss or ringing in ears NO YES: \_\_\_\_\_  
Chronic sinus problems or rhinitis NO YES: \_\_\_\_\_  
Nose bleeds NO YES: \_\_\_\_\_  
Difficulty breathing through the nose NO YES: \_\_\_\_\_  
Difficulty swallowing NO YES: \_\_\_\_\_

**CARDIOVASCULAR:**

Chest pain or angina pectoris NO YES: \_\_\_\_\_  
Palpitation NO YES: \_\_\_\_\_  
Shortness of breath with walking NO YES: \_\_\_\_\_  
Swelling of feet or ankles NO YES: \_\_\_\_\_

**RESPIRATORY:**

Chronic or frequent cough NO YES: \_\_\_\_\_  
Spitting up blood NO YES: \_\_\_\_\_  
Shortness of breath NO YES: \_\_\_\_\_  
Asthma or wheezing NO YES: \_\_\_\_\_

**GASTROINTESTINAL:**

Appetite changes NO YES: \_\_\_\_\_  
Difficulty swallowing NO YES: \_\_\_\_\_  
Frequent diarrhea or constipation NO YES: \_\_\_\_\_  
Stomach ulcers NO YES: \_\_\_\_\_

**GENITOURINARY:**

Blood in urine NO YES: \_\_\_\_\_  
Female - irregular periods NO YES: \_\_\_\_\_  
Male - prostate problems NO YES: \_\_\_\_\_

**PSYCHIATRIC:**

Depression NO YES: \_\_\_\_\_  
Psychosis NO YES: \_\_\_\_\_

**INTEGUMENTARY (Skin, breast):**

Rash or itching NO YES: \_\_\_\_\_  
Change in skin color/hair/nails NO YES: \_\_\_\_\_  
Varicose veins NO YES: \_\_\_\_\_  
Breast pain/lump/discharge NO YES: \_\_\_\_\_

**MUSCULOSKELETAL:**

Joint stiffness or swelling NO YES: \_\_\_\_\_  
Weakness in muscles or joints NO YES: \_\_\_\_\_  
Back pain NO YES: \_\_\_\_\_  
Cold extremities NO YES: \_\_\_\_\_

**NEUROLOGICAL:**

Lightheadedness or dizziness NO YES: \_\_\_\_\_  
Convulsions or seizures NO YES: \_\_\_\_\_  
Numbness or tingling sensation NO YES: \_\_\_\_\_  
Tremors NO YES: \_\_\_\_\_  
Paralysis NO YES: \_\_\_\_\_  
Slurred speech NO YES: \_\_\_\_\_  
Head injury NO YES: \_\_\_\_\_

**ENDOCRINE:**

Glandular or hormone disease NO YES: \_\_\_\_\_  
Thyroid disease NO YES: \_\_\_\_\_  
Diabetes NO YES: \_\_\_\_\_

**HEMATOLOGIC/LYMPHATIC:**

Slow to heal after cuts NO YES: \_\_\_\_\_  
Bleeding or bruising tendency NO YES: \_\_\_\_\_  
Blood clots NO YES: \_\_\_\_\_  
Past transfusion NO YES: \_\_\_\_\_  
Enlarged glands NO YES: \_\_\_\_\_

**ALLERGIC/IMMUNOLOGIC:**

Atopic disease NO YES: \_\_\_\_\_  
Rheumatoid pain NO YES: \_\_\_\_\_  
Dry eye, dry mouth NO YES: \_\_\_\_\_

Any other information of which the doctor should be aware \_\_\_\_\_

Are you concerned about the conditions of your skin or interested in learning more about facial aesthetics: NO \_\_\_\_\_ YES \_\_\_\_\_

Are you interested in knowing more about: Botox/Dysport: \_\_\_\_\_ Juvederm: \_\_\_\_\_ Restylane: \_\_\_\_\_ Kybella: \_\_\_\_\_ Latisse: \_\_\_\_\_

**PHYSICIAN USE ONLY:** Reviewed by \_\_\_\_\_ Date \_\_\_\_\_



LaFace by  
Laura Phan MD

**PATIENT AGREEMENT TO USE AND DISCLOSURE OF INFORMATION**

I hereby consent La Face by Laura Phan MD Inc to the use or disclosure of my individually identifiable health information in order to carry out treatment, payment, or health care operations. I have the right to review the practice’s Notice of Privacy Practices prior to signing this consent form. (Please refer to La Face by Laura Phan MD Inc’s Notices of Privacy Practices for a more complete description of such uses and disclosures.) La Face by Laura Phan MD Inc reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to La Face by Laura Phan MD Inc, 20398 Blauer Drive, Saratoga, CA 95070 or by downloading an electronic version at lauraphanmd.com.

I hereby consent La Face by Laura Phan MD Inc to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

I hereby consent La Face by Laura Phan MD Inc to mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminders and patient statements.

I hereby consent La Face by Laura Phan MD Inc to email to my home or other designated location any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminders and patient statements.

I have the right to request that La Face by Laura Phan MD Inc further restrict how my individual identifiable health information is used or disclosed to carry out treatment, payment, or health care operations. However, La Face by Laura Phan MD Inc is not required to agree to such requested restrictions. If La Face by Laura Phan MD Inc does agree to my requested restriction(s), such restrictions are then binding.

I have the right to revoke this Consent in writing at any time, except to the extent that La Face by Laura Phan MD Inc has already taken action in reliance upon prior consent. La Face by Laura Phan MD Inc may decline treatment if I do not sign this Consent Form, except to the extent that La Face by Laura Phan MD is required by law to treat individuals. If I sign this Consent and then revoke the Consent, La Face by Laura Phan MD Inc has the right to decline to provide further treatment to me as of the time of revocation.

Notice to Patients: Regulations require us to inform you that California “Medical Doctors are licensed and regulated by the Medical Board of California.” Medical Board contacts: (800) 633-2311. www.mbc.ca.gov.

**I HAVE READ AND UNDERSTAND THIS INFORMATION AND CONSENT TO THE ABOVE STATED TERMS.**

\_\_\_\_\_  
Patient’s (or Legal Guardian’s) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



LaFace by  
Laura Phan MD

## PATIENT AGREEMENT TO SERVICES AND FINANCIAL RESPONSIBILITIES

I, the undersigned, hereby authorize La Face by Laura Phan, MD, Inc to perform appropriate assessment, diagnostic, and treatment procedures. I also authorize La Face by Laura Phan, MD, Inc to obtain historical and eligibility data from various public and private entities, including but not limited to insurance claims data, pharmacy data or prior treating providers. The information may be necessary to determine eligibility for services and to properly diagnose and treat my conditions. Additional consents may be required to release this information.

I, the undersigned, have insurance coverage and assign directly to La Face by Laura Phan, MD, Inc all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for verifying network eligibility and benefit before and during assignment to La Face by Laura Phan, MD and am responsible for all **co-payments, co-insurances, deductibles and non-covered services**, as dictated by my insurance coverage. I understand that it is the policy of this practice that all **estimated co-payments, co-insurances, deductibles and non-covered services** are collected at the time of service. The amount is based on the contractual agreement with my insurance plan. I understand that I am personally responsible for payment of fees if authorization has not been obtained for whatever reason. I understand that being in net-work or having authorization **does not guarantee payment** by insurance plan. I understand that I am personally responsible for all charges whether or not paid by insurance by 90 days of service. I authorize La Face by Laura Phan, MD, Inc to release to my insurance carrier(s) any medical information necessary to secure payment of benefits. I permit a copy of this authorization to be used in place of the original. If I do not have health insurance, I am responsible for full payment for all services rendered by the Practice and agree to pay the entire amount at the time of service. I understand that if I do not pay in full I may be discharged from the Practice.

I understand that, in addition, to the examination, there may be diagnostic tests (i.e., visual field test, tear duct system probe and irrigation, CT and MRI scan, lab, etc.) and photographs taken as part of my evaluation. These are performed to help in the diagnosis and management of the medical conditions. I understand that, as a result, there may be additional out-of-pocket costs, as dictated by my insurance coverage.

I understand that it is the standard of care for Dr. Phan and the Practice to take patient photographs prior to and following the initiation of most clinical treatments and/or the performance of any surgical procedure on patients of the Practice. The photographs may be used for patient education or promotion and will not contain name or any other identifying information. I will inform the office if I do not wish to have my photos used for these purposes.

I do not wish to have my photos and videos used for patient counseling or medical education.

I do not wish to have my photos and videos used for promotion, including social media.

I understand that if I have not been examined by an eye doctor in the past year, as part of my examination with the Dr. Phan, I may be dilated, which involves having drops placed in my eyes. Dilation may cause blurred vision for several hours and make bright lights more bothersome, which vary from person to person. In extremely rare cases, dilation may trigger acute angle-closure glaucoma. I understand that I am to inform the doctor if I do not wish to have my eyes dilated at the time of examination.

I understand that if I “no-show” an appointment I will be charged \$100. I understand that if I no-show two appointments I will need to place a valid credit card on file when making future appointments and pay the full amount of the appointment if I no-show the third time. I understand that should I no show or cancel a total of three appointments, I may be discharged from the Practice.

All Medicare patients must sign lifetime beneficiary claim authorization: I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to La Face by Laura Phan MD, Inc., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made, and authorizes release of information necessary to pay the claim. If other health insurance is indicated in Item 9 of the electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductibles, copays, and non-covered services. Co-insurance and the deductible are based on the charge determination of Medicare carrier.

As a courtesy to our patients we will submit medical claims and continue to work with insurance plans to get the claims processed in a timely fashion. After 90 days from the date of service, we will no longer be contacting the insurance plans on the patient's behalf regarding claim status, and the patient is now responsible for full payment of services rendered. I understand that I am responsible for all charges not paid by insurance after 90 days from the date of service and that I am responsible for keeping my coordination of benefit up to date and working with my insurance plan to ensure for payment.

### **Recurring Payment Authorization**

As of March 1, 2020, in addition to storing credit card number and email address on Square for refunds, the Practice will use the stored information for recurring payments as convenient method of payments for services or products that medical insurance plan does not pay (i.e., deductible, co-insurance, co-pay, or non-medically necessary or cosmetic procedure or product.) Your card information is stored confidentially and securely by encryption on Square. Charges to your card are processed only after the claim has been filed to and processed by the insurance plan and remitted with an explanation of benefit. We will notify you via OnPatient or email, or postage mail if you do not have access to computer or email, prior to charging your credit card. We will also send you a receipt of payment via OnPatient, email or postage mail.

Recurring payments is convenient and efficient. It saves time, paper and postage. Your payments are always on time.

I, the undersigned, authorize and request La Face by Laura Phan, M.D., Inc. to charge my credit or debit card on file for balances due for services or products rendered the Practice.

I certify that I am an authorized user of this credit or debit card and will not dispute these transactions with my bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 15-day notification to La Face by Laura Phan, M.D., Inc., and the account must be in good standing.

\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name