LaFace by
Laura Phan MD

PATIENT INFORMATION SHEET

PLEASE PRINT **DATE:** ____________________

How did you select our Practice: ☐ **Dr.** ____________________, ☐ **Friend/Relative,** ☐ **Insurance Listing,** ☐ **Hospital,** ☐ **Print Material (specify)** ____________________, ☐ **Internet (specify)** ____________________ ☐ **Other (specify)** ____________________

PERSONAL INFORMATION:

Patient's Name ____ **Date of Birth** ___/___/______
First MI Last

Address ____ **Sex M F**

Phone# Home ______________ **Work** ______________ **Cell** ______________ **Email** ____________________

May we contact you (pls. circle all that apply) **Home / Work / Cell / Email** **Marital Status: S M Sep W D** **SS#** ________________

Employer ____ **Occupation** ____________________

Spouse's Name ______________________________ **Work Phone** ______________ **Cell** ______________

Contact in case of emergency: ____________________ **Phone** ______________ **Relationship to patient** ______________

Primary Care Physician ____
Name Address Telephone#

Referring Physician ____
(if other than primary physician) Name Address Telephone#

Eye Doctor ____
(if other than referring physician) Name Address Telephone#

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INSURANCE INFORMATION: Please bring your insurance card(s) at the time of your appointment.

Primary Insurance ______________________________ **Phone** ______________ **Group#** ______________

Subscriber's Name ____________________ **Policy#** ____________________ **Date of Birth** ____________

Secondary Insurance ______________________________ **Phone** ______________ **Group#** ______________

Subscriber's Name ____________________ **Policy#** ____________________ **Date of Birth** ____________

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PHARMACY OF CHOICE

1. ____
Name City Telephone# Zipcode

2. ____
Name City Telephone# Zipcode

3. ____
Name City Telephone# Zipcode

LaFace 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.

Condition		Condition	
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.

Condition		Condition	
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__________

PATIENT AGREEMENT TO USE AND DISCLOSURE OF INFORMATION

I hereby consent LaFace 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 LaFace by Laura Phan MD Inc's Notices of Privacy Practices for a more complete description of such uses and disclosures.) LaFace 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 LaFace by Laura Phan MD Inc, 20398 Blauer Drive, Saratoga, CA 95070 or by downloading an electronic version at lauraphanmd.com.

I hereby consent LaFace 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 LaFace 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 LaFace 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 LaFace 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, LaFace by Laura Phan MD Inc is not required to agree to such requested restrictions. If LaFace 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 LaFace by Laura Phan MD Inc has already taken action in reliance upon prior consent. LaFace by Laura Phan MD Inc may decline treatment if I do not sign this Consent Form, except to the extent that LaFace by Laura Phan MD is required by law to treat individuals. If I sign this Consent and then revoke the Consent, LaFace 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 LaFace by Laura Phan, MD, Inc to perform appropriate assessment, diagnostic, and treatment procedures. I also authorize LaFace 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 LaFace 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 LaFace 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 LaFace 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 LaFace 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

Our credit card processor may store credit card numbers used for recurring payments as a convenient method of payment 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. Charges to your card are typically processed only after the claim has been filed and processed by the insurance plan. There are times where we may charge your card before processing the claim but this would be discussed with you beforehand. We will notify you via OnPatient or email, or postage mail if you do not have access to a 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 LaFace 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 LaFace by Laura Phan, M.D., Inc., and the account must be in good standing.

______________________________________ ______________________

Patient’s (or Legal Guardian’s) Signature Date

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Print Name