



LaFace by
Laura Phan MD

PATIENT INFORMATION SHEET

DATE: _____

How did you select our Practice: Friend/Family: _____ Google/Search Instagram/Facebook
 Website Physician Referral: _____ Other: _____

PERSONAL INFORMATION:

Patient's Name _____
First MI Last

Address _____ Phone _____

Email _____ May we contact you about your care or our practice by Email: Yes No

Sex: M F Profession: _____ May we email you about our specials: Yes No

Contact in case of emergency _____ Phone _____ Relationship to patient _____

Primary Care Physician _____
Name City Telephone# Date last seen

Pharmacy of Choice _____
Name Telephone# Zipcode

PRIMARY CONCERNS:

- Upper eyelid skin/hooding Upper eyelid drooping Lower eyelid bag Eyebrow drooping
- Wrinkles/fine lines Volume loss Skin laxity Acne/acne scars Hyperpigmentation/melasma
- Rosacea/redness Sun damage Enlarged pores Body contouring Other: _____

Please describe your goals: _____

PREVIOUS COSMETIC TREATMENTS:

- Neuromodulators Dermal fillers Laser treatments Microneedling Chemical peels Biostimulants (i.e., PRP, PDRN, etc) Thread lift Facelift Upper blepharoplasty Lower blepharoplasty Ptosis repair Other: _____

Most recent cosmetic treatment and date: _____

Any prior complications or dissatisfaction with cosmetic treatments? No Yes: _____

Dr. Phan offers variety of non-surgical services. Are you interested in learning more about the following:

- Botox/Dysport RHA/Juvederm SkinVive Rejuran PRP+Nucleoskin Morpheus8 Accutite Facetite
- Bodytite Alma Hybrid Laser Nova threads Chemical peels Skincare

PHOTOGRAPHY: Please check all that applies.

- permit photography for medical record documentation only I permit
- photography for internal education/training I permit
- photography for marketing, website, and social media I permit

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

- | | | | |
|---------------------|---------------|--------------------------|---------------|
| Anemia | NO YES: _____ | Hepatitis | NO YES: _____ |
| Autoimmune disorder | NO YES: _____ | High blood pressure | NO YES: _____ |
| Bleeding disorders | NO YES: _____ | HIV/AIDS | NO YES: _____ |
| Blood clots | NO YES: _____ | Hyperpigmentation | NO YES: _____ |
| Cold sores | NO YES: _____ | Keloid/hypertrophic scar | NO YES: _____ |

Diabetes	NO YES: _____	Pregnant/breastfeeding	NO YES: _____
Dry eyes	NO YES: _____	Sleep apnea	NO YES: _____
Graves	NO YES: _____	Thyroid eye disease	NO YES: _____
Heart attack or stroke	NO YES: _____	Transfusion	NO YES: _____
Other medical condition(s): _____			

SKIN CONDITIONS: Eczema Psoriasis Rosacea Melasma Frequent rashes Easy bruising Delayed healing Excessive scarring Accutane use in last 12 months Retinoid use Recent tanning / sunburn Recent facial waxing None

SURGICAL HISTORY: Please list all prior surgeries.

LIFESTYLE:

Live alone: NO YES Occupation: _____
 Smoking: _____ packs/day since _____ Year quit: _____
 Alcohol: _____ drinks/day Illicit drugs: _____
 Daily exercise: _____

ALLERGIES:

Latex: NO YES Medication Allergies: _____

BLOOD THINNERS: Warfarin (coumadin) Eliquis (apixaban) Xarelto (rivaroxaban) Pradaxa (dabigatran) Savaysa (edoxaban) Heparin or Lovenox (enoxaparin) Aspirin Plavix (clopidogrel) Brilinta (ticagrelor) Effient (prasugrel) Ibuprofen/Advil/Motrin Naproxen/Aleve Fish oil/Omega-3 Vitamin E garlic, ginseng or ginkgo supplements Other herbal supplements

MEDICATION LIST:

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PHYSICIAN USE ONLY: Reviewed by _____ Date _____

PATIENT AGREEMENT TO SERVICES AND FINANCIAL RESPONSIBILITIES

I, the undersigned, hereby authorize **LaFace by Laura Phan MD** to perform appropriate assessments, diagnostic procedures, and treatment services.

I also authorize **LaFace by Laura Phan MD** to obtain relevant historical and eligibility information from public and private sources, including but not limited to insurance claims data, pharmacy records, and prior treating providers. This information may be necessary to determine eligibility for services and to properly diagnose and treat my condition(s). I understand that additional consents or authorizations may be required for the release of certain information.

I understand that, in addition to the examination, my evaluation may include diagnostic testing, such as visual field testing, tear duct probing and irrigation, CT or MRI imaging, laboratory studies, and clinical photography. These may be performed to assist in the diagnosis and management of my medical condition(s). I understand that these services may result in additional out-of-pocket costs depending on my insurance coverage and benefits.

I understand that it is the standard of care for **Dr. Phan** and the Practice to take patient photographs before and after many clinical treatments and surgical procedures. These photographs may be used for medical documentation, patient education, or promotional purposes and will not include my name or other direct identifying information. I understand that I should inform the office if I do not want my photographs used for patient education or promotional purposes.

I understand that if I have not been examined by an eye doctor within the past year, **Dr. Phan** requires that I have an eye examination before undergoing surgery with her.

I understand the Practice’s appointment policy as follows:

- If I do not show up for a scheduled appointment without notice, I will be charged a **\$100 no-show fee**.
- If I no-show for **two appointments**, I will be required to place a valid credit card on file or pay a deposit before scheduling future appointments.
- If I no-show a **third appointment**, I may be charged the full appointment amount.
- If I no-show or cancel a total of **three appointments**, I may be discharged from the Practice.

I understand that **LaFace by Laura Phan MD** is committed to maintaining a safe, professional, and respectful environment. Lewd, abusive, hostile, or threatening language, communication, behavior, or acts toward physicians, staff, or other patients will not be tolerated. Such conduct may result in being discharged from the Practice.

Patient’s (or Legal Guardian’s) Signature

Date

Print Name