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 about your care or our practice by Email: Yes No **Marital Status:** S M Sep W D **SS#** _____

May we email you about news and special offers? Yes No

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

_____
Name City Telephone# Zipcode

LaFace by Laura Phan, MD, Inc MEDICAL
HISTORY QUESTIONNAIRE

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:_____

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

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/day since_____ Year quit: _____

Alcohol: _____ drinks/day Illicit drugs: _____

ALLERGIES:

Latex: NO YES Medication Allergies: _____

CURRENT MEDICATIONS **(Include eye medication, aspirin, advil, ibuprofen, naproxyn, other non-steroidal anti- inflammatory drugs, vitamins, and nutritional supplements)**

Name	Dose	Frequency	Reason

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

Cancer_____ Stroke_____
Diabetes_____ Other _____
Heart attack_____

REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the **past six months**.

CONSTITUTIONAL:
Weight gain or loss 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 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 interested in knowing more about: ☐ Blepharoplasty ☐ Asian Blepharoplasty ☐ Brow Lift ☐ Ptosis repair
☐ Botox/Dysport ☐ RHA/Juvederm ☐ SkinVive ☐ Rejuran ☐ PRP+Nucleoskin ☐ Morpheus8 ☐ Accutite
☐ Facetite ☐ Bodytite ☐ Alma Hybrid Laser ☐ Nova threads ☐ Chemical peel ☐ Skincare

PHYSICIAN USE ONLY: Reviewed by_____Date_____

20398 Blauer Drive, Saratoga, CA 95070 Tel: (408) 502-5000 Fax: (408) 502-5505

PATIENT AGREEMENT TO USE AND DISCLOSURE OF INFORMATION

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

I hereby consent LaFace by Laura Phan MD 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 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 to email me, using the address on file, 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 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 is not required to agree to such requested restrictions. If LaFace by Laura Phan MD 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 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

PATIENT AGREEMENT TO POLICIES, SERVICES AND FINANCIAL RESPONSIBILITIES

I, the undersigned, hereby authorize LaFace by Laura Phan MD to perform appropriate assessment, diagnostic, and treatment procedures. I also authorize LaFace by Laura Phan MD 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 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 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, Dr. Phan requires that I be examined by my eye doctor before any surgery with Dr. Phan.

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 or pay a deposit 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.

Our practice 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.

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 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 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 MD and the account must be in good standing.

_____ _____

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

_____

Print Name