



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.

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

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, gingseng 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 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 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 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

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