TABAN MD
OCULOPLASTIC SURGERY

MEHRYAR (RAY) TABAN, MD, FACS
Assistant Clinical Professor at UCLA
Board-Certified

2320 Bath St., Suite 301, Santa Barbara, CA 93105
Tel: (805) 682-4444 | Fax: (805) 682-1999

9735 Wilshire Blvd, Suite 319, Beverly Hills, CA 90212
Tel: (310) 278-1836 | Fax: (310) 278-1828

www.TabanMD.com

NEW PATIENT INFORMATION

Name: ____ Date of Birth: ________________ ☐Male ☐Female
LAST FIRST MI

Social Security #:__________-_________-__________ E-Mail Address: ________________________________

Address: ____
STREET CITY STATE ZIP

Home #: ______________________ Cell #: ______________________ Work #: ______________________

If patient is under 18, name of responsible party: ______________________________

Occupation: ____________________________________ Employer: ____________________________________

EMERGENCY CONTACT

Name: ____ Relationship: ____________________________

Home #: ____________________ Work #: ____________________ Cell #: ________________________

PATIENT DEMOGRAPHIC:

This information is requested per Government guidelines. It is ok to decline.

Language: ☐English ☐Other: ______________________

Race: ☐African/African American ☐Asian/Asian American ☐*Decline*
☐Caucasian/European American ☐Native American/Native Alaskan
☐Native Hawaiian/Other Pacific Islander ☐Other

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐*Decline*

INSURANCE INFORMATION

PRIMARY INSURANCE		***SECONDARY INSURANCE***	
☐Medicare	☐United Health Care	☐Medicare	☐United Health Care
☐Anthem Blue Cross	☐Cigna	☐Anthem Blue Cross	☐Cigna
☐Blue Shield	☐Aetna	☐Blue Shield	☐Aetna
☐Other:		☐Other:	☐AARP

Authorization to Release & Assignment of Insurance Benefits

I UNDERSTAND THAT ANY MEDICAL CARE I RECEIVE WILL BE BILLED TO MY HEALTH INSURANCE COMPANY. IT IS MY RESPONSIBILITY TO PROVIDE A COPY OF MY INSURANCE CARD AND CORRECT DATE OF BIRTH TO MEHRYAR TABAN, MD FOR THIS PURPOSE. I AUTHORIZE THE MEHRYAR TABAN, MD TO FURNISH MY INSURANCE COMPANY WITH ALL INFORMATION THAT THEY MAY REQUEST REGARDING MY MEDICAL TREATMENT.

I ASSIGN TO MEHRYAR TABAN, MD ALL INSURANCE PAYMENTS RELATIVE TO THE CLAIMS SUBMITTED BY MEHRYAR TABAN, MD. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY OFFICE VISIT CO-PAY, IF ANY, AND FOR MY DEDUCTIBLE AND MY CO-INSURANCE, IF ANY, ONCE MY CLAIM(S) ARE PROCESSED. I UNDERSTAND THAT IF MY INSURANCE DENIES MY CLAIM(S), OR IF I HAVE NO INSURANCE, I AM PERSONALLY FINANCIALLY RESPONSIBLE FOR MY MEDICAL CARE.

EVEN THOUGH YOU HAVE ASSIGNED YOUR BENEFITS TO DR. TABAN, YOUR INSURANCE COMPANY MAY SEND PAYMENT FOR SERVICES DIRECTLY TO YOU. PLEASE ENDORSE THE BACK OF THE CHECK, OR SEND A PERSONAL CHECK FOR THE AMOUNT AND A COPY OF THE EXPLANATION OF BENEFITS TO OUR BEVERLY HILLS OFFICE UPON RECEIPT. FAILURE TO REMIT ENTIRE AMOUNT PAID BY YOUR INSURANCE COMPANY WILL RESULT IN IMMEDIATE COLLECTION ACTION OF THE FULL BILLED AMOUNT.

____ ____________________

Patient Signature (or person authorized to sign for patient) **Date**

TO WHOM SHOULD WE THANK FOR THIS VISIT

☐Referring Doctor: ________________________________ Phone #: ________________________

☐Friend/Family: ____________________________ ☐Internet Search ☐ Other (specify): ________________

REASON FOR TODAY'S VISIT:

____

Are you interested any finding out if you are a candidate for any of the following cosmetic options:

☐Fillers ☐Botox ☐Latisse ☐Cosmetic Eyelid and/or Facial Surgery

Office Use: ☐ BH ☐ SB ☐ __________

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MEDICAL CONSULTATION SERVICES

A ***Medical Evaluation*** is an Oculoplastic exam which focuses on structural and functional aspects such as eyelid position, proper eyelid closure, lacrimal system, tear production, and general eye health. A Medical Evaluation *is required* prior to planning any surgery whether cosmetic or reconstructive. Most patients do their medical evaluation on their first visit and it is covered by most insurance plans. Please provide your medical insurance card.

I consent to a Medical Evaluation – billed to insurance. *(If no insurance, the fee is $200.)*
I understand that my insurance will be billed for my medical evaluation and I am responsible for my office visit co-pay today, if any, and my deductible and co-insurance once my claim is processed. Without insurance, the fee for a medical evaluation is $200 and is due on the day of my evaluation.

I grant authority to my physician to perform a Medical Evaluation and to administer medically necessary treatment(s), if any, which may be deemed advisable or necessary during the course of my care.

____ ____________________

Patient Signature (or person authorized to sign for patient) **Date**

PERSONAL COSMETIC CONSULTATION SERVICES

A ***Personal Cosmetic Consultation*** is a detailed discussion which focuses on the aesthetic appearance of the eyelids and face and the options available to improve their appearance. A personal cosmetic consultation is non-insurance covered.

I consent to a Personal Cosmetic Consultation with Dr. Mehryar (Ray) Taban - $200
I understand the fee to consult with Dr. Taban about my aesthetic facial appearance is $200 and is due on the day of consultation. This fee is not covered by any insurance plan and is non-refundable, *but will be applied towards any procedures I elect.* I understand that any and all cosmetic treatments, services and surgeries are non-insurance covered. I agree to pay in full in advance for these services.

Dr. Mehryar Taban has advised me that he limits his practice to Oculo-Facial Plastic Surgery. I acknowledge and agree that I will seek another medical professional for ophthalmic or other vision related services as required.

I grant authority to my physician to perform a Medical Evaluation and to administer medically necessary treatment(s), if any, which may be deemed advisable or necessary during the course of my care.

____ ____________________

Patient Signature (or person authorized to sign for patient) **Date**

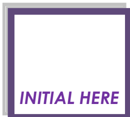
CONSENT FOR PHOTOGRAPHS FOR MEDICAL FILE

In order to properly diagnose, treat, and serve our patients, we often take pictures to record changes and track progress of many medical conditions. <u>These photos remain confidential and are for your medical file only.</u>

I hereby authorize the attending physician, Oculoplastic fellow and members of the surgical staff to take photographs of me for my medical file during the course of my care. <u>I understand that my photos will remain confidential and are for my medical file only.</u>

USE OF PHOTOGRAPHS

As professors at the Jules Stein Eye Institute at UCLA we welcome any and all opportunities to educate others. Your case, no matter how common, how rare, how challenging, how straightforward, etc. is extremely helpful for physician and patient education through lectures, textbooks, and other forms of publications.



(OPTIONAL) I hereby consent to and authorize the use and reproduction by you, or anyone authorized by you, of photographs and/or images which you have taken of me without further compensation to me.

☐<u>Social Media/Photo,Video Consent Form</u>

____ ____________________

Patient Signature (or person authorized to sign for patient) **Date**

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PRIVACY NOTICE/ HIPAA REGULATIONS

*Our office is in full compliance with the **Health Insurance Portability and Accountability Act (HIPAA).***
*A full description of the **HIPAA Regulations** is available at all times at our Front Desk. This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Protected health information means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.*

I hereby acknowledge that this Notice in its entirety is available and may be requested by me at any time prior to or during the course of my care. I may request a copy in person or request that a copy be sent to me via mail, email or fax.

____ ______________________________
Patient Signature (or person authorized to sign for patient) **Date**

Please list those people with whom we may discuss your personal healthcare information (doctors, family members, friends, personal assistants, nurses, etc.)

Name: ____________________________________ Relationship:______________________ Phone #: __________________

Name: ____________________________________ Relationship:______________________ Phone #: __________________

MY PHARMACIES & PHYSICIANS (names and cities)

Pharmacy: ____________________________________ Phone #: ______________________

Primary Care: _________________________________ Phone #: ______________________

Other Physicians/Specialties:

Name: ____________________________________Phone #: ______________________Specialty: _______________

Name: ____________________________________Phone #: ______________________Specialty: _______________

MY ALLERGIES (please list all allergies)

☐No Known Drug Allergies ☐Penicillin ☐Vicodin ☐Adhesive ☐Iodine ☐Latex

____

MY MEDICATIONS

☐No Current Medications
☐See List Provided

SYSTEMIC MEDICATIONS	DOSAGE	FREQUENCY

EYE MEDICATIONS	DOSAGE	FREQUENCY

MY PREVIOUS SURGERIES (including Eye Surgeries)

____
____
____

SOCIAL HISTORY:

Do you currently smoke? ☐No ☐Yes (If yes: #______ packs per day/week) **Have you ever smoked?** ☐No ☐Yes

Do you currently drink? ☐No ☐Yes (If yes: #______ glasses per day/week)

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REVIEW OF SYSTEMS

PAST MEDICAL HISTORY: *Circle all that apply.*

Family Medical History: diabetes, hypertension, migraine,

Past Medical History: diabetes, hypertension, cancer, thyroid, arthritis, easy bleeding, asthma, headache, other

OCULAR HISTORY: *Circle all that apply.*

Family Eye History: glaucoma, retinal detachment, strabismus, blindness, ARMD

Past Eye History: glaucoma, amblyopia, double vision, flashes, floaters, lost vision episodes, halos, pain, stinging, burning, dryness, itching, sandy feeling, tearing, trouble reading, blurred vision

SYMPTOMS

Have you recently experienced any of the following? (Check all that apply)

- ☐Weight loss
- ☐Fever
- ☐Night sweats
- ☐Hearing Problems
- ☐Bloody Nose
- ☐Chest Pain or palpitations
- ☐Chronic Cough or Bloody Sputum
- ☐Shortness of breath
- ☐GI Symptoms
- ☐Headaches
- ☐Numbness
- ☐Weakness of arms/legs
- ☐Dizziness
- ☐Joint Pain
- ☐Muscle Pain
- ☐Rashes
- ☐Easy Bruising
- ☐Urinary Symptoms
- ☐Swelling of fingers/toes
- ☐Redness/Scaling
- ☐Unexplained Bleeding
- ☐Double Vision
- ☐Dry Eyes
- ☐Eye Redness
- ☐Eye Pain/Burning
- ☐Tearing

OUT OF TOWN PATIENTS:

We strive to provide the possible care to our patients, but there are limitations for out of town patients in regards to post operative care. Dr. Taban is always available, however circumstances may make it necessary to receive postoperative care local to you.

____ ____________________

Patient Signature (or person authorized to sign for patient) **Date**

Reviewed with patient by: ____________________ ____________________

Technician/Staff **Doctor**

NOTICE OF VIDEO SURVEILLANCE: *This building & facility is equipped with a video surveillance system. This is done for your protection and for the protection of this facility and its operators.*

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Credit Card Authorization and Consent form

I,________________________________ hereby authorize Taban MD to charge my credit card for any services performed and/or past due balances.

Type of Card: ☐Visa ☐MasterCard ☐American Express ☐Discover

Credit Card Number: ____

Expiration Date: ____

Name of Cardholder: ____

Credit Card Billing address: ____

Total amount to be charged: $_______________

Authorized Signature of Cardholder_________________________________

Signing this, I acknowledge the charges described here on and assume full responsibility for said charges and agree to honor and abide by the terms of payment. I acknowledge and accept Taban MD terms and conditions, as stated in the patient information packet I have previously filled out.

Signature:___________________________________ Date:______________________