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 ☐Other
LAST FIRST MI

Social Security #: _____-_____-_____ E-Mail Address: _____

Address: _____
STREET CITY STATE ZIP

Home #: _____ Mobile #: _____ Work #: _____

If patient is under 18, name of responsible party: _____ DOB: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home #: _____ Work #: _____ Mobile#: _____

PATIENT DEMOGRAPHIC:

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

Language: ☐English ☐Other: _____

Race/Ethnicity: _____ ☐*Decline*

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 ☐ OTHER_____

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 always available 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. However, if you post anything online our office has the right to reply.*

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**

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.*

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

CONSULTATION SERVICES

A **Personal Consultation** is a detailed discussion which focuses on the aesthetic and/or functional appearance of the eyelids and face and the options available to improve their appearance and/or function. The consultation fee is $500. 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 but functional treatments can be courtesy billed to your insurance on your behalf. I agree to pay in full in advance for these services. I grant authority to my physician to perform evaluation and administer necessary treatment(s), if any, which may be deemed advisable or necessary during the course of my care.

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.

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.***

INSURANCE INFORMATION

PRIMARY INSURANCE	*SECONDARY INSURANCE*

Authorization to Release & Assignment of Insurance Benefits

I UNDERSTAND THAT ANY MEDICAL CARE I RECEIVE CAN BE BILLED TO MY HEALTH INSURANCE COMPANY IN COURTESY FASHION. IT IS MY RESPONSIBILITY TO PROVIDE CORRECT INFORMATION TO MEHRYAR TABAN, MD. I AUTHORIZE MEHRYAR TABAN, MD INC AND/OR BEVERLY HILLS TRIANGLE SURGERY CENTER TO FURNISH MY INSURANCE COMPANY WITH ALL INFORMATION THAT THEY MAY REQUEST REGARDING MY MEDICAL TREATMENT. I ASSIGN TO MEHRYAR TABAN, MD AND BEVERLY HILLS TRAINGLE SURGERY CENTER ALL INSURANCE PAYMENTS RELATIVE TO THE CLAIMS SUBMITTED BY MEHRYAR TABAN, MD. 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.

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. *These photos remain confidential and are for your medical file only.*
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. I understand that my photos will remain confidential and are for my medical file only.

_____ _____

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

As professor at the Jules Stein Eye Institute at UCLA, I welcome any opportunity 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 for social media, website.**

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

PATIENT MEDICAL HISTORY

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)

☐None ☐Penicillin ☐Vicodin ☐Adhesive ☐Latex ☐Anesthesia (specify below) ☐Other (specify below)

_____

MY MEDICATIONS **SYSTEMIC & EYE MEDICATIONS**

☐No Current Medications
☐See List Provided

_____ _____
_____ _____
_____ _____
_____ _____

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)

REVIEW OF SYSTEMS

PAST MEDICAL/EYE HISTORY:

Family Medical/Eye History:

Past Medical/Eye History:

SYMPTOMS

Please list any symptoms you have:

_____ _____

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