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: _____ DOB:_____

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/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 ☐ SB ☐ _____

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.*

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.*

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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. The consultation fee is $200 which is due on the day of the consultation. Our office will courtesy bill your insurance on your behalf if desired. Please provide your insurance information to our office. *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.*

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 fee is $200. 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 consent to a ☐ Medical Evaluation or ☐ Cosmetic Consultation.

_____ _____

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

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*	
☐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 IN COURTESY FASHION. IT IS MY RESPONSIBILITY TO PROVIDE CORRECT INFORMATION TO MEHRYAR TABAN, MD. I AUTHORIZE MEHRYAR TABAN, MD INC 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 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**

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) Initials**_____ 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 and lectures.

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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**