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# Cosmetic and Reconstructive Surgery

## Ophthalmic Plastic Surgery

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*Welcome to our office!*

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### About your visit

Our office is dedicated to providing outstanding care in Cosmetic and Reconstructive Ophthalmic Plastic Surgery.

Please complete the registration and other forms that you have received in the mail. This information familiarizes us with your medical history and helps us to screen you for possible surgery.

We make every effort to be punctual. **You should allow one hour** for your initial visit, although the actual length of your appointment may vary.

At the time of your visit, please present your registration form and questionnaire to Cindra at the front desk. You will be taken to an examination room, where Kari Jo, our Registered Nurse (R.N.), will review your current problem, general medical condition, and vision. Dr. Levin will examine relevant aspects of your eyes and face and discuss treatment with you. You may meet our patient care coordinator, Dona, who will

help arrange any recommended surgery. You will not have surgery at the time of your visit.

insurance programs for which we are a "preferred provider" and Medicare, we will submit the initial claim form. We can always help you with insurance details, but you will be responsible for payment for services regardless of the status of your insurance claim.

### About HMOs

Some insurance plans now require pre-authorization prior to the office visit. Because there

are dozens of differing plans, our office may not be able to determine this for you in advance of your appointment. To prevent embarrassing confusion, be certain to obtain authorization (when required) from your "gatekeeper" physician before your appointment. Unfortunately, we are unable to see HMO patients without authorization.

### A few hints...

- Please complete and remember to bring the registration form and health questionnaire that you received in the mail. These questions help us to understand your problem and screen you for possible surgery.
- Please bring old full-face photographs from your late teens or twenties. Old photographs help Dr. Levin evaluate your eyes and face and help guide any requested surgery.
- Bring a list of all vitamins, medicines, and eyedrops you are using. With rare exceptions, if a procedure or biopsy is recommended, you will be asked to schedule a return appointment.
- Please remove any eye make-up prior to your appointment. If you wear contact lenses, please bring your glasses and a contact lens case.
- If you have a complex problem or have had previous ophthalmic plastic surgery, please bring copies of your medical records, operative reports, and special tests including the actual CT or MRI scans.

### About Insurance

While we have considerable experience in dealing with insurance companies, we do not know and cannot certify what professional, laboratory, or operating room services will be covered by your insurance. We are always willing to write or call your insurer describing your condition, the anticipated fees, and other pertinent information. You may wish to check with your insurance carrier about coverage before proceeding with surgery.

To assist patients with

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Peter S. Levin, M.D.

525 South Dr., Suite 101

(650) 964-9600

Mountain View, CA 94040

(650) 964-1424 (fax)

# Peter S. Levin, M.D.

# Ophthalmic Plastic Surgery

525 South Drive, Suite 101

Mountain View, CA 94040

650) 964-9600

## Patient Registration. Welcome to our office.

Please print and fill out completely. Please provide insurance cards to photocopy.

Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_

last first middle

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell phone (provide only if OK to use) \_\_\_\_\_

Home address: \_\_\_\_\_

Street City State Zip

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_

*We will respect your confidentiality.*

May we leave messages: At home ( ) yes ( ) no. At work ( ) yes ( ) no. On your cell phone ( ) yes ( ) no.

Emergency contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

What doctor referred you to Dr. Levin? \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Address of referring doctor: \_\_\_\_\_

Primary Care physician: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Primary Care physician address/city/zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Spouse/Parent: \_\_\_\_\_

Spouse's/Parent's Employer: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Subscriber name: \_\_\_\_\_

Insurance I.D. #: \_\_\_\_\_ Group number: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Subscriber name: \_\_\_\_\_

Insurance I.D. #: \_\_\_\_\_ Group number: \_\_\_\_\_

### PLEASE SIGN BELOW AND RETURN TO THE FRONT DESK

I, the undersigned, have insurance coverage and assign directly to Peter S. Levin, M.D. all surgical and / or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that some insurance plans have "preferred" panels of physicians or require prior authorization prior to seeing physicians. I understand that I am responsible for payment of fees if authorization has not been obtained for whatever reason. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Date \_\_\_\_\_ Signed \_\_\_\_\_

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 Peter S. Levin, M.D., 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 releasing 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 the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

Date \_\_\_\_\_ Signed \_\_\_\_\_

The evaluation that you receive is specialized and is limited to your facial plastic problem. I am aware that Dr. Levin is not providing an "eye examination" and that this visit does not replace your need for an eye exam.

Date \_\_\_\_\_ Signed \_\_\_\_\_

Your Name: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Occupation: \_\_\_\_\_ Age \_\_\_\_\_

**Symptoms you currently are or have recently been experiencing (please circle yes or no):**

Watery eyes.....	YES	NO	Easy bruising .....	YES	NO
Discharge from eyes.....	YES	NO	Abnormal bleeding tendency	YES	NO
Sinus problems .....	YES	NO	Shortness of Breath:		
Difficulty breathing through nose	YES	NO	Sitting .....	YES	NO
Difficulty swallowing.....	YES	NO	Walking around home .	YES	NO
Chest pain/angina.....	YES	NO	Walking stairs.....	YES	NO
Frequent nose bleeds .....	YES	NO	Walking several blocks	YES	NO

**Your Allergies: Do you have allergies to:**

Environmental/hay fever ...	YES	NO	Describe reaction to drug _____
Local anesthetic.....	YES	NO	Describe reaction to drug _____
Penicillin, sulfa, or other antibiotics.....	YES	NO	Describe reaction to drug _____
Iodine/Betadine.....	YES	NO	Describe reaction to drug _____
Codeine or other narcotics	YES	NO	Describe reaction to drug _____
Other drug allergies:			
Allergies to Latex or tape?	YES	NO	Describe reaction _____

**Family History-Have your parents or siblings had? (please circle yes or no)**

Diabetes.....	YES	NO	High blood pressure.....	YES	NO
Thyroid disease .....	YES	NO			

**Personal Medical History-Have you ever had? (please circle yes or no):**

Vision loss not correctable with glasses or contacts .....	YES	NO	Hepatitis, Jaundice or liver disease	YES	NO
Glaucoma .....	YES	NO	Tuberculosis.....	YES	NO
Cataracts/cataract surgery	YES	NO	AIDS or HIV infection .....	YES	NO
Retinal Disease.....	YES	NO	Diabetes .....	YES	NO
Asthma/emphysema .....	YES	NO	Graves Disease/thyroid problems.....	YES	NO
High Blood Pressure.....	YES	NO	Problems with immune system.....	YES	NO
Rheumatic Heart Disease.	YES	NO	Anemia .....	YES	NO
Heart murmur.....	YES	NO	Transfusion .....	YES	NO
Mitral valve prolapse.....	YES	NO	Cancer .....	YES	NO
Other heart disease (heart attack, angina, blocked heart vessels, heart failure)	YES	NO	Cold sores or fever blisters.....	YES	NO
			Skin cancer .....	YES	NO
			Sleep apnea.....	YES	NO

**Any health problems not mentioned above:** \_\_\_\_\_

Have you ever had a tooth removed? YES NO  
 If "yes", did you have unusual bleeding at that time? YES NO  
 Have you been told to take antibiotics prior to dental or surgical procedures? YES NO  
 If yes, what drug and how do you take it. \_\_\_\_\_

**Vision History:**

Do you wear glasses for distance vision? YES NO  
 Do you wear contact lenses? YES NO  
 Have you been told that you have "dry eyes"? YES NO  
 Have you had LASIK? ... YES NO  
 Who is your eye doctor? \_\_\_\_\_  
 When was your last eye examination? \_\_\_\_\_  
 Do you take artificial tears or other eye drops? YES NO Please list: \_\_\_\_\_

Your Name: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Plastic Surgery History: (please circle yes or no)**

Have you ever had:

Chemical peel?	YES	NO
Laser skin treatment?	YES	NO
Botox?	YES	NO
Facial or eyelid surgery or any cosmetic surgery?	YES	NO Specify (if yes)

If you use skin care products, please list: \_\_\_\_\_

After surgery /injury do you develop:

Pigmented scars?	YES	NO
Large/thick/keloid scars?	YES	NO
Any other scarring abnormality?	YES	NO

List other surgeries you have had: \_\_\_\_\_

Do you take aspirin or cousin drugs such as Advil, ibuprofen, naproxyn or other non-steroidal anti-inflammatory drugs? YES NO. If YES, can you stop these 10 days before surgery? YES NO

Medications and doses that you presently take (attach separate sheet if needed): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over-the-counter drugs, Vitamins & nutritional supplements (attach separate sheet if needed) \_\_\_\_\_  
\_\_\_\_\_

Do you smoke cigarettes? YES NO. If "yes", how many packs a day and for how many years? \_\_\_\_\_

Are you or could you possibly be pregnant? (QUESTION FOR WOMEN) YES NO

How many alcohol containing drinks do you have in an average week? \_\_\_\_\_

Do you live alone? YES NO Name of person living with you? (We prefer that patients have company for 24 hr. after surgery) \_\_\_\_\_

Are you aware that results of medical treatment and surgery vary from patient to patient and cannot be guaranteed? YES NO

Would you like recommendations on improved appearance of your eyelids, face, or skin at the time of your consultation? YES NO If yes, please list any specific areas of interest  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for taking the time to accurately record your health history!**

*It is the policy of this facility to resuscitate all patients and call for transfer to the Hospital in the event of a cardiac emergency. If you have an Advanced Health Care Directive, you may ask us to keep a copy in your medical record to be transferred to the hospital in the event of such an emergency.*

**Peter S. Levin MD  
525 South Drive, Suite 101  
Mountain View CA 94040**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Peter S. Levin, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Peter Levin MD's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Peter S. Levin, M.D. reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Peter S. Levin, M.D. Privacy Officer at 525 South Drive, Suite 101; Mountain View CA 94040

With my consent, Peter S. Levin, M.D. may 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 and healthcare operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Peter S. Levin, M.D. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements.

With my consent, Peter S. Levin, M.D. may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements.

I have the right to request that Peter S. Levin, M.D. restrict how he uses or discloses my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). However, the practice is not required to agree to my requested restrictions. By signing this form, I am consenting to Peter S. Levin, M.D.'s use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Peter S. Levin, M.D. may decline to provide treatment to me.

**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: Telephone: (800) 633-2322. Internet address: [www.mbc.ca.gov](http://www.mbc.ca.gov)**

I acknowledge that I have read this information regarding the Protected Health Information and the Medical Board of California.

\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Your Name

## **Peter S. Levin, M.D.**

525 South Drive, Suite 101  
Mountain View, CA 94040  
(650) 964-9600

### **Directions to the Office**

**Hwy 101 coming from the North:** *(From San Francisco, San Mateo County and much of the East Bay):*

Take Hwy 101 going South. Stay in the right two lanes and exit to the right onto Hwy 85 (South) which is marked as Hwy 85 (South)/Cupertino/Santa Cruz (Exit 398 B). Go past the Central Expressway exit on Hwy 85 and take the **second** exit which is called North {82} Junction/El Camino Real/Grant Road/Exit 22A. The first light you come to will be El Camino Real. Go up Grant Road 5 more street lights (1.0 miles) and turn right on South Drive. Go past El Camino Hospital to the end of South Drive. The Orchard Creek Medical Center is the last building on the left. Our office is on the ground level.

**Hwy 101 coming from the South:** *(San Jose, San Jose International Airport, Santa Clara, Monterey)*

Take Hwy 101 going North. Exit at 237 West (Mountain View-Alviso Road) towards Mountain View. Follow this road for 4-5 miles. Cross over El Camino Real. (Past this intersection, the street changes its name to Grant Road.) Go up Grant Road 5 more street lights (1.0 miles) and turn right on South Drive. Go past El Camino Hospital to the end of South Drive. The Orchard Creek Medical Center is the last building on the left. Our office is on the ground level.

**Hwy 280 coming from the North:** *(San Francisco, SF International Airport, San Mateo County)*

Exit at Magdalena Avenue. Turn left onto Magdalena at the stop sign.

Continue past the lights at Foothill Expressway and Fremont Avenue (Magdalena changes names to Springer Road.) Go past the stop sign at Berry and turn right on Covington Road. Please note this is a *25 MPH zone* that is carefully patrolled and takes you by a school. Turn left when Covington dead ends at Grant Road. Go 0.1 miles and turn left onto South Drive. Go past El Camino Hospital to the end of South Drive. The Orchard Creek Medical Center is the last building on the left. Our office is on the ground level.

**Hwy 280 coming from the South (San Jose) and Hwy 17 coming Santa Cruz**

Exit onto HWY 85 North (Mtn View), take the first exit which is Fremont Avenue. Turn left at the street light, onto Fremont Avenue for 1.0 miles. Turn right onto Grant Road and continue on Grant Road for 1.0 miles. Turn left on South drive. Go past El Camino Hospital to the end of South Drive. The Orchard Creek Medical Center is the last building on the left. Our office is on the ground level.

**Hwy 85 coming from the South:** *(South San Jose, Saratoga)*

Take the Fremont Avenue exit off Hwy 85. Turn left at the street light, onto Fremont Avenue for 1.0 miles. Turn right onto Grant Road and continue on Grant Road for 1.0 miles. Turn left on South drive. Go past El Camino Hospital to the end of South Drive. The Orchard Creek Medical Center is the last building on the left. Our office is on the ground level.

**Special note from the East Bay:**

You may take the SF-Oakland Bay Bridge, San Mateo Bridge, or Dumbarton Bridge and follow directions **“Hwy 101 from the North”** above **OR**

You may take Hwy 880 to Hwy 237 West/Mountain View. Cross over El Camino Real. (Past this intersection, the street changes its name to Grant Road.) Go up Grant Road 5 more street lights (1.0 miles) and turn right on South Drive. Go past El Camino Hospital to the end of South Drive. The Orchard Creek Medical Center is the last building on the left. Our office is on the ground level.

**PETER S. LEVIN, M.D.**

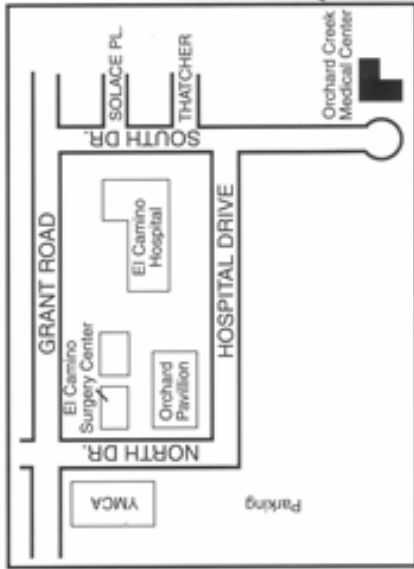
COSMETIC FACIAL AND LASER SURGERY  
OPHTHALMIC PLASTIC SURGERY

**ORCHARD CREEK MEDICAL CENTER**

525 SOUTH DRIVE, SUITE 101  
MOUNTAIN VIEW, CA 94040

(650) 964-9600

**SCALE**  
0 1/4 1 Mile



**OFFICE**

