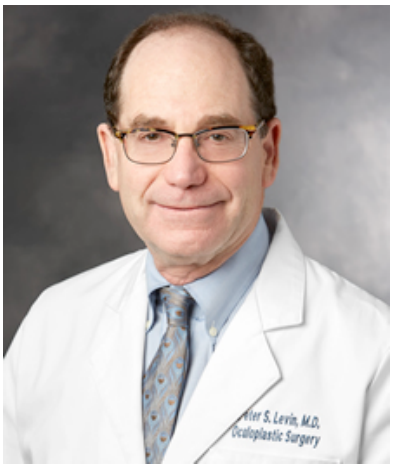
# Meet Dr. Levin




# An Eye for Excellence

The face is a complex, delicate area that needs the individualized care that Dr. Levin has been providing for over 25 years. Specializing in surgery giving the eyes a youthful and natural appearance, he has performed several thousand facial plastic surgical procedures and teaches his craft to ophthalmologists, cosmetic surgeons, fellows and residents. He also serves on the medical staffs at El Camino Hospital, Stanford Medical Center, Waverley Surgical Center and Mills-Peninsula Hospital.

Dr. Levin has been elected by his peers for inclusion in Best Doctors in America®. (www.BestDoctors.com/us). Locally, he has been listed as a "Top Doc" in the San Jose Magazine poll of Best Doctors in Silicon Valley and in the San Francisco Magazine poll of Best Doctors. Before opening his private practice in Mountain View in l992, Dr. Levin was the first full-time Director of Ophthalmic Plastic and Orbital Surgery in the Department of Ophthalmology at Stanford. At Stanford, he served as Director or Co-Director of programs in Ophthalmic Plastic and Orbital Surgery for over 20 years. Currently he is Adjunct Clinical Professor of Ophthalmology at Stanford. At UC San Francisco, he has served as faculty for the Fellowship in Ophthalmic Plastic Surgery, sponsored by the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS).

Dr. Levin received an Ivy League education at Brown University in Providence, Rhode Island, obtaining baccalaureate degrees in History and Biology, and received his medical degree from the Johns Hopkins School of Medicine in Baltimore. He subsequently served as resident and chief resident in ophthalmology at the California Pacific Medical Center in San Francisco, where also he received specialty training in Ophthalmic Plastic Surgery. He went on to complete the prestigious Ophthalmic Plastic Surgical Fellowship at Duke University in Durham, NC, and then expanded his expertise to surgery of the entire face and neck by completing a preceptorship in facial plastic surgery.

Three of the hospitals where Dr. Levin has trained or taught – Hopkins, Duke, and Stanford -- are ranked by US News and World Report as among the top 15 in the country.

In 2015, Dr. Levin was approved by the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS), as Fellowship Director for the 2-year Stanford University Training Program in Ophthalmic Plastic Surgery which began in July 2017.

## Certification and Credentials

Dr. Levin is board certified by the American Board of Ophthalmology. He is a Fellow of the American Academy of Facial Plastic Surgery, the American Academy of Ophthalmology, and the American Society of Ophthalmic Plastic and Reconstructive Surgery. For our cosmetic surgery patients, we use our office surgical suite approved as an Accredited Outpatient Surgical Setting by the Medical Board of California.

## Academic Appointment

Adjunct Clinical Professor; Department of Ophthalmology; Stanford University School of Medicine. https://stanfordhealthcare.org/doctors/l/peter-levin.html

Peter S. Levin, M.D. **Ophthalmic Plastic Surgery**

706 Webster Street Palo Alto, CA 94301 (650) 964-9600

## Patient Registration. Welcome to our office.

Please fill out completely

Name: _____
last first middle

By what name should we call you? _____

Birth Date: _____/____/_____

Home address: _____
Street City State Zip

Email address : _____ Cell phone: ( ) _____

Home phone: ( ) _____ Work phone: ( ) _____

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

By email? ( ) yes ( ) no.

Emergency contact person: _____ Phone: _____

How did you learn about Dr. Levin? _____

Primary Care physician: _____ Telephone: ( ) _____

Primary Care physician street/city/zip: _____

*PLEASE SIGN BELOW AND RETURN TO THE FRONT DESK*

I, the undersigned, understand that I am seeing Dr. Levin for cosmetic services or other services that are NOT covered by insurance.

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 _____

**PETER S. LEVIN, M.D.** **NEW PATIENT HEALTH HISTORY (Page 1 of 2)**

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_____ |
| Allergies to egg or soy? | YES | NO | Describe reaction_____ |
| Allergies to Botox or fillers? | YES | NO | Describe reaction_____ |

**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 |
| | | | Tuberculosis..... …….. | YES | NO |
| Glaucoma ..... | YES | NO | AIDS or HIV infection ..... …… | YES | NO |
| Cataracts/cataract surgery | YES | NO | Diabetes..... …… | YES | NO |
| Retinal Disease..... | YES | NO | Graves Disease/thyroid problems…… | YES | NO |
| Asthma/emphysema..... | YES | NO | Problems with immune system……..YES | | NO |
| High Blood Pressure..... | YES | NO | Anemia..... …… | YES | NO |
| Rheumatic Heart Disease. | YES | NO | Covid-19..... …… | YES | NO |
| Heart murmur..... | YES | NO | Cancer ..... …… | YES | NO |
| Mitral valve prolapse..... | YES | NO | Cold sores or fever blisters…… | YES | NO |
| Other heart disease (heart attack, angina, blocked heart vessels, heart failure) | 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 instructed to take antibiotics prior to every 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____/____/_____

**Cosmetic Surgery/Treatment History: (please circle yes or no)**

Have you ever had:
- Chemical peel? YES NO
- Laser skin treatment? YES NO
- Botox? YES NO
- Facial Fillers YES NO
- Facial or eyelid surgery or any cosmetic surgery? YES NO

Please expand on the specifics of any cosmetic surgery/treatments:_____

_____

_____

_____

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 take. (Attach separate sheet if needed). If no medications are taken, write "None": __

_____

_____

_____

_____

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? _____

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

_____

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.*

*For office use only:*

NewhealPaloAlto052020

☒ History reviewed and amended as indicated above

☐ MD Signature (optional)

**Peter S. Levin MD** **Disclosures: HIPAA/Medical Board Regulation/Advanced Medical Directives**

**SECTION 1: 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 P.O. Box 999; Palo Alto, CA 94302.

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.

**Section 2: Medical Board Regulations**
**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**

**Section 3: Advanced Health Care Directives**
It is the policy of this facility to resuscitate all patients including those with "Do Not Resuscitate" (DNR). In the event of a medical emergency we call paramedics requesting for transfer to the Hospital for all patients. 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.

Please circle YES if you have a have an Advanced Health Care Directive and feel free to bring it to us at your next appointment. *YES. I have an Advanced Health Care Directive*

I acknowledge that I have read this information regarding the Protected Health Information, the Medical Board of California, and Advanced Directives. I have no further questions.

_____ _____
Patient's (or Legal Guardian's) Signature Date

_____
Print Your Name

Peter S. Levin MD
706 Webster Street; Palo Alto CA 94301
(650) 964-9600

# Informed Consent – COVID-19 RISK

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.
I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Peter Levin and the staff at his are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19.

However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Peter Levin and his staff to proceed with treatment.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. The local and state policy on cosmetic surgery is somewhat confusing but it appears that cosmetic procedures are beginning in our community and we do not expect an impact on supplies available to nearby hospitals. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

_____
Patient or Person Authorized to Sign for Patient Date/Time

Witness_____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____