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FACIAL PLASTICS & DERMATOLOGY

RONALD L. MOY, M.D., EDGAR FINCHER, M.D., PH.D., LISA CHIPPS, M.D., M.S., M.S. JENNIFER HERRMANN, M.D.

AMERICAN COLLEGE OF MOHS SURGERY
AMERICAN SOCIETY FOR DERMATOLOGIC SURGERY
AMERICAN ACADEMY OF DERMATOLOGY
AMERICAN ACADEMY OF FACIAL PLASTIC SURGERY
AMERICAN ACADEMY OF COSMETIC SURGERY

P: 310.274.5372 F: 310.274.5380 The Rodeo Collection 421 N. Rodeo Dr, Ste. T-7 Beverly Hills, CA 90210

Full Name: Date of Birth: Date:

Have you received your first and second dose of COVID-19 vaccine?

Yes No

<u>Positive responses to any of the questions below would likely indicate a deeper discussion with</u> the practice before proceeding with your appointment. Please make sure to contact the office.

Do you have fever, or have you felt hot or feverish recently? (14-21 days)	Yes	No
Are you having shortness of breath or other difficulties breathing? Not due to any chronic conditions.	Yes	No
Do you have a cough?	Yes	No
Any other flu-like symptoms, such as sore throat, headache or fatigue?	Yes	No
Have you experienced recent loss of taste or smell?	Yes	No
Are you in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	Yes	No
Have you traveled in the past 14 days to any regions affected by COVID-19? (As relevant to your location)	Yes	No

This is an acknowledgement that I have agreed to have my medical care provided at the Moy-Fincher-Chipps (MFC) Medical office.

I understand that it is required to wear a face mask that fully covers the nose and mouth at the time of my appointment.

I understand that MFC will be following and observing all healthcare guidelines and precautions during our clinical and office hours.

I acknowledge that MFC can provide all the necessary health safety materials during my medical visit. I understand that all the standard HIPAA, OSHA and CLIA procedures are being followed. I understand if I exhibit any signs of illness, I will be asked to leave the office immediately for the safety of our staff and patients.

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