ALASKA FACIAL PLASTIC SURGERY & ENT
CHRISTINA MAGILL MD

ADULT NEW PATIENT PAPERWORK

FULL LEGAL NAME: _____ **DOB:** _____ **TODAY'S DATE:** _____

WHAT IS YOUR PRIMARY LANGUAGE? _____ **WHAT IS YOUR RACE?** _____

WHAT IS YOUR MARITAL STATUS? _____

WHAT IS YOUR OCCUPATION/WHO IS YOUR EMPLOYER? _____

PHONE: _____ **EMAIL:** _____

HOW DO YOU PREFER TO BE CONTACTED?

☐ TEXT MESSAGE ☐ PHONE ☐ EMAIL

MAY WE LEAVE YOU MESSAGES? PLEASE CIRCLE THE NUMBER(S) OF YOUR PREFERRED OPTIONS:

1. YOU CAN LEAVE A MESSAGE ON MY ANSWERING MACHINE ASKING FOR A CALL BACK.

2. YOU CAN LEAVE A MESSAGE ON MY ANSWERING MACHINE LEAVING BASIC APPOINTMENT CONFIRMATION INFO.

3. YOU CAN LEAVE A MESSAGE ON MY ANSWERING MACHINE LEAVING MULTIPLE DETAILS SUCH AS QUOTE INFO, A RESPONSE TO A SPECIFIC QUESTION, OR DETAILED INSTRUCTIONS.

4. YOU CAN LEAVE A MESSAGE WITH A FAMILY MEMBER.

WHO IS YOUR EMERGENCY CONTACT?

NAME _____ PHONE _____ RELATION _____

WERE YOU REFERRED BY ANOTHER PROVIDER? WHO? _____

WHAT IS YOUR PREFERRED PHARMACY? _____

IS YOUR CONDITION THE RESULT OF A WORK INJURY OR AN AUTO ACCIDENT? _____

HAVE YOU HAD COVID-19? IF SO, WHEN? _____

HAVE YOU BEEN VACCINATED AGAINST COVID-19? IF SO, WHEN? _____

ADULT HEALTH HISTORY FORM

PATIENT NAME: _____ DOB: _____ AGE: _____

PREFERRED NAME (IF OTHER) _____ VISIT DATE: _____

WHO REFERRED YOU TO OUR OFFICE? _____ PRIMARY CARE PHYSICIAN: _____

WHAT IS THE **MAIN REASON** FOR YOUR VISIT TODAY? _____

_____

HOW LONG HAS THIS PROBLEM EXISTED? _____

ALLERGIES / SENSITIVITIES TO MEDICATIONS (PLEASE DESCRIBE REACTION)

CURRENT MEDICATIONS **WITH DOSAGE** (INCLUDE OVER THE COUNTER AND HERBAL SUPPLEMENTS)

PREFERRED PHARMACY (NAME, CROSS STREETS, OR PHONE #) _____

DO YOU NOW OR HAVE YOU EVER HAD A HISTORY OF: (PLEASE CHECK THOSE THAT APPLY)

- ☐ ANESTHETIC COMPLICATIONS
- ☐ ASTHMA
- ☐ ANXIETY
- ☐ BLEEDING DISORDER
- ☐ CANCER
- ☐ DIABETES
- ☐ EYE DISEASE (GLAUCOMA, RETINAL DETACHMENT, CATARACT)
- ☐ FAMILY HISTORY OF ABNORMAL BLEEDING
- ☐ FAMILY HISTORY OF ANESTHETIC COMPLICATIONS
- ☐ GERD (REFLUX)
- ☐ KELOIDS OR POOR SCARRING
- ☐ KIDNEY DISEASE
- ☐ LUNG DISEASE
- ☐ PSYCHIATRIC DISORDER
- ☐ RADIATION TREATMENTS
- ☐ SEIZURE
- ☐ HEART DISEASE (HEART ATTACK, CHEST PAINS, IRREGULAR HEARTBEAT, CF…)
- ☐ HEART MURMUR REQUIRING PREVENTIVE ANTIBIOTICS
- ☐ HEPATITIS OR LIVER DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HIV / AIDS
- ☐ IMPLANTS/ARTIFICIAL DEVICES (HEART VALVE, JOINTS, PACEMAKER)
- ☐ INFLAMMATORY/AUTOIMMUNE DISEASE (LUPUS, WEGENER'S, MS)
- ☐ SLEEP APNEA
- ☐ SPEECH DELAY
- ☐ STROKE
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ WOULD HEALING COMPLICATIONS

OTHER MEDICAL PROBLEMS: _____

DO YOU HAVE ANY RELIGIOUS REASON WHY YOU WOULD NOT ACCEPT BLOOD PRODUCTS? YES NO
HAVE YOU OR ANYONE IN YOUR FAMILY BEEN TREATED FOR A MRSA SKIN INFECTION? YES NO

ADULT HEALTH HISTORY FORM (CONT.)

NAME: _____ **DOB:** _____ **DATE:** _____

LIST ALL PRIOR SURGERIES AND HOSPITALIZATIONS:

SURGERY/HOSPITALIZATION	YEAR	SURGEON/FACILITY

LIST ANY ILLNESSES THAT RUN IN YOUR FAMILY:

ILLNESS	FAMILY MEMBER

TOBACCO USE (CIGARETTES, CIGARS, PIPES, CHEW, SNUFF, VAPE) ☐ CURRENT USER ☐FORMER USER (QUIT DATE: _____) ☐ NEVER

IF CURRENT OR FORMER SMOKER: # PER DAY _____ FOR _____ YEARS

ALCOHOL: ☐ YES (DRINKS PER WEEK _____) ☐ NOT CURRENTLY ☐ NEVER CONSUMED

RECREATIONAL OR ADDICTIVE DRUGS (COCAINE, MARIJUANA, ECT.) ☐ YES _____ ☐ NOT CURRENTLY ☐ NEVER

FOR FEMALE PATIENTS: ARE YOU PREGNANT **OR** TRYING TO GET PREGNANT? ☐ YES ☐ NO

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU: **(IF EXPERIENCED IN THE PAST, PLEASE NOTE NEXT TO CHECKED BOX)**

- ☐ RASHES, BRUISING, SKIN PROBLEMS
- ☐ RECENT WEIGHT LOSS OR GAIN
- ☐ FATIGUE
- ☐ FEVER, CHILLS, NIGHT SWEATS
- ☐ LOUD SNORING
- ☐ EXCESSIVE SLEEPINESS
- ☐ BREATHING STOPS DURING SLEEP
- ☐ WAKE UP FEELING UNRESTED
- ☐ HEART MURMUR
- ☐ PALPITATIONS
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ WHEEZING
- ☐ CHEST TIGHTNESS
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ FAINTING
- ☐ WEAKNESS
- ☐ EAR RINGING
- ☐ HEARING LOSS
- ☐ DIZZINESS/VERTIGO
- ☐ EAR PAIN
- ☐ MOUTH/THROAT DRYNESS
- ☐ HOARSENESS
- ☐ CHOKING
- ☐ DIFFICULTY SWALLOWING
- ☐ LUMPS IN NECK
- ☐ PAINFUL SWALLOWING
- ☐ HEAT/COLD INTOLERANCE
- ☐ EXCESSIVE THIRST
- ☐ CHANGE IN SHOE/HAND SIZE
- ☐ INDIGESTION/HEARTBURN
- ☐ NAUSEA/VOMITING
- ☐ DIARRHEA/CONSTIPATION
- ☐ ABDOMINAL PAIN
- ☐ CLOUDED VISION
- ☐ DRY EYES
- ☐ DOUBLE VISION
- ☐ NASAL CONGESTION OR DRAINAGE
- ☐ FACIAL PRESSURE/PAIN
- ☐ NASAL BLEEDING

SIGNATURE OF PATIENT: _____ **DATE:** _____

POLICIES AND CONSENTS

(REQUIRES SIGNATURE) IMPORTANT INFORMATION:

To avoid delays in the insurance claims process, please present your insurance card at your initial visit. All ENT and Facial Plastic Surgery services rendered are charge to the patient's insurance. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have completed the above questions and certify that this information is true and correct to the best of my knowledge. I will notify you of any change in my insurance status or any of the above information. I authorize the staff to perform all necessary services needed during diagnosis and treatment. I also authorize the provider to release all information required to process insurance claims. All cosmetic services that are rendered are to be paid at the time of appointment unless arrangements have been pre-approved by the Office Supervisor.

If you are an adult signing for your own appointment, please acknowledge and agree to the above by signing on the line below.

x_____

(REQUIRES SIGNATURE) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

(Located at the front desk - please ask the receptionist if you would like to review or have a copy). I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices. I hereby authorize Christina Magill, MD, Kami Howlett PA-C, Sarah Thibodeau PA-C, and staff to provide all information to my insurance carriers concerning my illness and treatments.

If you are an adult signing for your own appointment, please acknowledge and agree to the above by signing on the line below.

x_____

(REQUIRES SIGNATURE) FINANCIAL POLICY AND NO CALL – NO SHOW POLICY:

Thank you for choosing AFPENT as your ENT and Facial Plastic Surgery Clinic. We are committed to providing patients with the highest quality of care. To accomplish this, it is important that we establish a clear financial policy for all treatments. Every patient is required to read and agree to this policy (by typing your full name below) before services are rendered. A new agreement will be required annually, or if your insurance has changed. Questions regarding the financial policy should be directed to our billing or office supervisor.

IF YOU HAVE INSURANCE: All insurance companies will be billed by our office as a courtesy if you provide a copy of the current insurance card at the time of service. It is your responsibility to contact your insurance company to verify your benefit coverage at our office. Ask if they allow for exceptions of in-network coverage when there is not a contracted in-network provider in your area or if they will consider reimbursing at a higher rate for services and procedures. Co-pays and deductibles are to be paid at the time of service. If you are unsure what your co-pay amount is or unsure if you have met your deductible, you will be charged 20% of your total bill during your visit. Please be aware that few insurance companies cover all medical costs. Some insurances pay fixed allowances while others pay only a percentage of costs. Many insurance companies use a fee schedule derived from providers outside this region and may not be applicable to this area. You are ultimately responsible for any portion of your bill that insurance does not cover. Your coverage is a contract between you and your insurance carrier, questions regarding coverage will need to be directed to them.

NO CALL - NO SHOW POLICY: All patients are expected to show up for their scheduled appointments. If you are unable to make an appointment, please contact us as soon as you are aware that you have a conflict. A patient who does not show up for a scheduled appointment and does not leave a message to let us know they cannot come, will not be permitted to schedule appointments with us in the future.

IF YOU DO NOT HAVE INSURANCE: You will be expected to pay for your first consultation in full at the time of service. If further testing, procedures, or surgery is necessary, each case will be addressed individually at that time.

COSMETIC, SELF PAY, OR CASH PAY SERVICES: All cosmetic services are to be paid in full at the time of service. Surgery fees for cosmetic procedures are due two weeks in advance of your surgery date. Any cosmetic services rendered that are not paid in full at the time of visit will result in the patient not receiving any further treatments until the account is paid in full. Any charges quoted to a patient are considered estimates and are not guaranteed. Your doctor must evaluate a patient to determine the level of the office visit or what procedure is necessary before a final charge can be given. Accounts that become delinquent will be submitted to a collections agency and will be subject to credit reporting. In addition, patients whose accounts are submitted to a collection’s agency will be considered discharged by our practice. We accept cash, check, major credit cards, Care Credit, and FSA cards. We will charge a $25 fee for returned checks. I acknowledge that I have read and understand this financial policy. I authorize AFPENT to accept the assignment of claims submitted to my insurance carrier. Reproduced copies of this authorization will be as valid as the original.

If you are an adult signing for your own appointment, please acknowledge and agree to the above by signing on the line below.

x_____

(SIGNATURE OPTIONAL) PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY:

I give permission for Christina Magill, MD, Kami Howlett PA-C, Sarah Thibodeau PA-C, and staff to take photographs of my treatment(s) area(s) for diagnostic purposes and to document for the medical record of my response to the therapy or procedure. I agree that these photographs are the property of Alaska Facial Plastic Surgery & ENT and Christina Magill, M.D., and I give my permission for these photographs to be used for teaching purposes, for use in scientific publications, books, journals, lectures, seminars, and electronic media. It is understood that in any such publication I shall not be identified by name, and the appropriate measures shall be made to protect my identity. Although these photographs will be used without identifying my information such as my name, I understand that it is possible that someone may recognize me. I understand that I will not receive any compensation for the use of my photographs for scientific and teaching/educational purposes from any party. I confirm that this consent form has been explained to me in terms which I understand.

If you are an adult signing for your own appointment, please acknowledge and agree to the above by signing on the line below.

x_____