ALASKA FACIAL PLASTIC SURGERY & ENT
CHRISTINA MAGILL MD

PEDIATRIC NEW PATIENT PAPERWORK

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

WHAT IS THE CHILD'S PRIMARY LANGUAGE? _____ WHAT IS THE CHILD'S RACE? _____

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 HAS LEGAL CONSENT FOR NON-EMERGENT APPOINTMENTS? _____

WHO HAS LEGAL CONSENTS FOR NON-EMERGENT SURGERIES? _____

IS OCS INVOLVED OR ARE THERE ANY CUSTODY ISSUES WE SHOULD BE AWARE OF?

_____

WHO IS THE EMERGENCY CONTACT FOR THE CHILD?

NAME _____ PHONE _____ RELATION TO CHILD _____

WAS THE CHILD REFERRED BY ANOTHER PROVIDER? WHO? _____

WHAT IS YOUR PREFERRED PHARMACY? _____

HAS THE CHILD EVER HAD COVID-19? IF SO, WHEN? _____

HAS THE CHILD EVER BEEN VACCINATED AGAINST COVID-19? IF SO, WHEN? _____

PEDIATRIC HEALTH HISTORY FORM

PATIENT NAME: _____ **DOB:** _____ **AGE:** _____

PREFERRED NAME (IF OTHER) _____ **VISIT DATE:** _____

WHO REFERRED YOU TO OUR OFFICE? _____ **PEDIATRICIAN:** _____

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 #) _____

MEDICAL HISTORY: (CHECK ALL THAT APPLY)

- ☐ ANESTHETIC COMPLICATIONS
- ☐ ASTHMA
- ☐ BLEEDING DISORDER OR BRUISING
- ☐ CONGENITAL HEART DISEASE
- ☐ DID NOT PASS NEWBORN HEARING SCREENING
- ☐ PREMATURITY
- ☐ REFLUX OR EASY VOMITING
- ☐ SLEEP APNEA
- ☐ SPEECH DELAY

OTHER HEALTH CONDITIONS: _____

PLEASE LIST ALL PRIOR SURGERIES AND HOSPITALIZATIONS:

SURGERY/HOSPITALIZATION	YEAR	SURGEON/FACILITY

PLEASE LIST ANY ILLNESSES THAT RUN IN YOUR FAMILY

ILLNESS	FAMILY MEMBER

PEDIATRIC HEALTH HISTORY FORM (CONT.)

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

BIRTH HISTORY

BIRTH WEIGHT: _____ **LBS.** _____ **OZ. HOW MANY WEEKS GESTATION?** _____ **CURRENT WEIGHT:** _____

PREGNANCY COMPLICATIONS (LIST ANY) _____

NICU STAY? YES ____ **NO** ____ **NEWBORN HEARING SCREEN RESULTS: PASS** _____ **FAIL** _____ **UNKNOWN** _____

IMMUNIZATIONS: UP TO DATE OR DELAYED? _____

PARENTAL TOBACCO USE: DO PARENTS OR PRIMARY CARE GIVERS SMOKE? YES ___ NO ___

i. WHO SMOKES? _____
ii. IS TOBACCO USED INSIDE OR OUTSIDE THE HOME?
iii. IS TOBACCO USED AROUND CHILDREN?

WHO HAS LEGAL CUSTODY? (LIST ALL) _____

WHO DOES CHILD LIVE WITH? _____

PARENTS ARE: (CIRCLE ONE) MARRIED NOT MARRIED PARTNERED SEPARATED DIVORCED

DOES YOUR CHILD ATTEND: DAYCARE PRESCHOOL GRADE IN SCHOOL? _____

NUMBER OF SIBLINGS: _____ (_____ # OF BOYS, _____ # OF GIRLS)

PARENTS' OCCUPATION: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO CHILD: **(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
- ☐ MOUTH BREATHING

SIGNATURE OF PARENT: _____ **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 filling out on behalf of your child, do not sign your child's name.

x_____

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

Located at the front desk - please ask 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 filling out on behalf of your child, do not sign your child's name.

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 filling out on behalf of your child, do not sign your child's name.

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 filling out on behalf of your child, do not sign your child's name.

x_____