ALEXIS D. FURZE, M.D., F.A.C.S.
Facial Plastic & Reconstructive Surgery ♦ Nasal & Sinus Surgery ♦ Head & Neck Surgery

PATIENT INTAKE FORM

Date Completed: _____

General Information / Demographic Information:

Full Name: _____ Sex: _____ DOB: _____

Social Sec. #: _____ Email: _____ Please select one: Mr / Mrs / Ms / Miss

Home / Cell Phone: _____ Marital Status: _____

Address: _____City, State, Zip Code: _____

Ethnicity: _____ Race: _____ ☐ Prefer not to Answer Preferred Language:_____

Would you like to be granted electronic access to your health record from this office? _____ **YES / _____ NO**

How did you hear about us? _____

Insurance Information:

Name of primary cardholder (if other than patient): _____

DOB of primary cardholder: _____ Primary Ins. Company: _____

Member ID #: _____Group #: _____

We would like to communicate with your primary doctor and, if you were not referred by your primary doctor, your referring practitioner. Please complete:

Primary Practitioner - Name/Address/Fax: **Referring Practitioner – Name/Address/Fax:**

_____ _____

_____ _____

Pharmacy Info:

Pharmacy Name: _____ Phone#: _____

Cross Streets / Address: _____

Past Medical History: (Please include dates where applicable)

Major medical events / Hospitalizations: _____

Previous Surgeries: _____

Ongoing Medical Problems: _____

Family Medical History – Please state the relationship of those with the medical issue:

_____

Social History/Lifestyle: Do you currently smoke? _____ Are you previous smoker? _____

If yes to either: How much? _____How many years? _____ Year Quit: _____

Alcohol Intake? _____ Illicit Drugs? _____ Occupation: _____

Medication List: Please list the medications and dosages that you **CURRENTLY** take?

_____ _____ _____

_____ _____ _____

Medication Allergies: Please list any medication allergies and specific reaction when taken.

_____ _____ _____

Medical Questionnaire: Tell us about the symptom(s) or reason(s) for your appointment with us:

Quality (pain, pressure, swelling, etc.): _____

Location(s): _____ Severity (1-10 scale, 1=mild, 10 = severe): _____

How long have you had the issue? _____ Are symptoms constant or do they come and go? _____

What makes the symptom(s) better? _____ Worse? _____

What other symptoms are related to your primary issue? _____

What treatments have you attempted that have not helped? _____

Estimated Height: _____ Estimated Weight (lbs.) _____

Review of body systems: Please check if you have **RECENTLY** had any of these symptoms:

☐ Fever	☐ Vomiting	☐ Easy Bleeding	☐ Back Pain
☐ Chills	☐ Ulcers	☐ Rashes	☐ Joint Pain
☐ Night Sweats	☐ Heartburn	☐ Skin Lesions	☐ Bone Pain
☐ Unusual Weight Loss or Gain	☐ Heart Palpitations	☐ Hair Changes or Excessive Loss	☐ Muscle Pain/Weakness
☐ Excessive Thirst	☐ Chest Pain	☐ Skin Changes	☐ Vision Changes
☐ Unusual swelling or lumps	☐ Shortness of Breath	☐ Urinary Problems	☐ Neurological Events
☐ Abdominal Pain	☐ Cough	☐ Kidney Problems	☐ Seizures
☐ Nausea	☐ Anemia	☐ Liver Issues	☐ Headache

Acknowledgment

By initialing and dating the form below, I acknowledge that I have been given access to our Notice of Privacy Practices.

_____ Initial _____ Date

_____ **Initial Here** to consent to receive personally identifiable mailings from us (announcements, office notifications, etc.)

_____**Initial Here** to consent to receive personally identifiable phone calls and voicemails from us (patient reminders / notifications, office follow up's, etc.)

_____**Initial Here** to consent to receive E-mail correspondence from us with personally identifiable information (Morph patient photos, lab results, patient reminders / notifications, correspondence to patient questions, etc.)

CONSENT AND BILLING POLICIES

Medical Consent: The care of the patient is under the control and supervision of Alexis D. Furze, M.D. The undersigned consents to any medical/surgical treatments, x-ray examinations, laboratory tests and hospital services rendered under the general and special instructions of Dr. Furze.

Billing Policy: I (patient or patient legal guardian) understand that if the current insurance information is not presented at the time of service, I will be responsible for full payments at the time services are rendered. In the situation when a third party is financially responsible to cover the cost of your visit, the primary and ultimate responsibility for payments rests with you (patient, parent, or legal guardian). We will attempt to verify your insurance benefits at the time of your visit, however, this is no guarantee of coverage as the final determination of benefits is made by the insurance company at the time claims are actually received and processed based on your individual insurance plan. We accept a wide number of insurance plans as well as Medicare. We only accept a few HMO plans. We must follow the terms of these plans including any mandatory co-payments and deductibles that are required at the time service is rendered.

Assignment of Benefits/Insurance Authorization: I hereby assign to the above named physicians and Alexis D. Furze, M.D., Inc. all rights, title and interests in the benefits payable to me by an insurance policies or benefits plan under which I am covered for services rendered by the physician. I also authorize and direct my insurance carrier to pay directly to the above named physicians any benefits due to me under my insurance plan. I also authorize the above named physicians or their representatives to release to my insurance carrier any medical information necessary to process my claim(s). I understand that I am responsible for all charges not covered by the assignment along with any deductibles, co-insurance, and/or "Out of Network" co-payments and I, hereby, promise to pay any remaining balance due.

_____ _____ _____

Signature of Patient or Representative **Printed Name of Patient or Representative** **Date**

Nasopharyngoscopy & Flexible Laryngoscopy Patient Acknowledgment

In order for Dr. Furze to do a complete and thorough Ear-Nose-Throat Examination, a Nasopharyngoscopy (gently inserting a scope to examine your nose) and a Flexible Laryngoscopy (gently inserting a flexible fiber optic scope through the nose to examine your throat) may need to be performed at the time of your office consultation, visit, or postoperative follow-up. These are routinely used to accurately examine and diagnose the many complex and serious illnesses and disorders found in the Head and Neck anatomy.

Most insurance companies have routinely covered these procedures but sometimes they may be applied towards your annual deductible if you have not already met it for the year, and you would be responsible for any unpaid balance. These procedures billed are not based on time, but procedure done. They can be categorized incorrectly under "surgery" on your copy of the insurance company's explanation of benefits. We can assure you that we do not bill these in-office procedures as surgeries but some individual insurance companies still code them this way by their choice.

Please direct any questions and/or concerns you may have in regard to any office Endoscopic procedures to our office staff at the beginning of your visit and to Dr. Furze prior to any of these routine examinations being performed.

Sign below, stating that you have received, read, understood and agreed to the aforementioned.

_____ _____ _____

Signature of Patient or Representative **Printed Name of Patient or Representative** **Date**

CONSENT FOR RELEASE & USE OF PHOTOGRAPHS AND/OR VIDEO

I, _____(Patient Name), am a patient of Alexis D. Furze, M.D., Inc. / Facial Plastic Surgery OC, and have been or will be photographed and/or video recorded during the course of my treatment.

I hereby grant Dr. Alexis D. Furze the on-going and unrestricted right to use my photographs/video for general information, continuity of care, physician referral, online web pages, education, scientific, medical and public relations purposes and to permit others to use them for these purposes.

This consent may only be revoked in writing, signed by myself and delivered to Dr. Alexis D. Furze. Such revocation shall thereafter be effective as to any further use not already committed to by Dr. Alexis D. Furze. This consent is in consideration of consultations conducted and services performed and those to be conducted and performed by Dr. Alexis D. Furze.

Acknowledgment: By signing the line below I acknowledge the above.

_____ _____ _____

Signature of Patient or Representative **Printed Name of Patient or Representative** **Date**