Baylor College of Medicine
GIVING LIFE TO POSSIBLE

The Bobby R. Alford Department of Otolaryngology-Head and Neck Surgery

Jamail Specialty Center
1977 Butler Blvd, Suite E5.100 (5th Floor)
Houston, TX 77030
Tel: 713-798-5900 ▪ Fax: 713-798-3801

Welcome to the Bobby R. Alford Department of Otolaryngology. We are very pleased that you have chosen us for your care. In order for us to meet your needs and manage your care effectively, it is important that we share the following information with you.

BEFORE YOUR APPOINTMENT:
If you are a new patient to our center, it is important that you request your medical records (operative reports, lab testing, diagnostic imaging, pathology reports) and bring them with you to your appointment. This medical record information is vitally important to your care and is necessary in order for the doctor to complete a thorough assessment upon your first visit. If you do not have your medical records available at your first visit, then there may be limitations on what we can do during your first visit and it is possible that you may need to return for a second visit once those records are made available to our office. In addition, please bring relevant past CT/MRI/Pet Scan films or CDs.

DAY OF YOUR VISIT:
Please consider traffic and parking time when you plan your trip to the clinic so that you can arrive on time. New Patients should arrive 15 minutes prior to their appointment to complete check in procedures. If you are more than 20 minutes late you may be asked to reschedule or wait to be seen at the end of clinic.

You will be asked to fill out a medical questionnaire (included in this mailing/email) regarding your health, to review documents regarding your health privacy and about charges for certain tests that may not be covered by your insurance.

1. The questionnaire must be filled out before going into the exam room.
2. Please be sure you bring a photo I.D., your insurance card(s), and co-payment amount.
3. If this is your first visit to our center please verify that your records have been faxed to our office prior to your scheduled appointment.
4. Make sure you sign-up for MyChart during your visit.

   <u>Services currently available through MyChart include</u>:
   a. Secure messaging with your physician
   b. Online appointment requests
   c. Prescription renewal
   d. Viewing test results
   e. General health information
   f. Making payments

SCHEDULING AN APPOINTMENT:
Please make your appointments by calling 713-798-5900. If you are visiting the clinic and need to set up a return appointment with your doctor for a later date, you may do so at the front desk as you checkout.

Please have your insurance, referral information and routine pharmacy phone number and location available at the time you call.

1. If you have an HMO plan, a referral from your primary care physician is required. It is your responsibility to get the referral. If this referral is not in place at the time of your visit, you will be responsible for payment in full at the time of service. You should call your primary care physician's office prior to your visit to ensure this is complete.
2. Your pharmacy information is recorded so that your prescriptions can be sent electronically to that specific pharmacy when needed.
3. Your insurance may be re-verified at every visit, as many insurance policies are approved on a 30 day basis. Please bear with us on this seemingly repetitive issue.

CHANGING AN APPOINTMENT:
A 24 hour minimum advance notice to cancel or change an appointment is appreciated so that your appointment time may be given to another patient in need of care.

PRESCRIPTION REFILLS:
Requests for prescription refills are accommodated by having your pharmacy send a refill request by fax or through our electronic medical record system. For mail order requests, please leave a message with the patient resource center for a prescription refill. Refills can also be requested electronically via Mychart. Prescription refills will be processed by the end of the following work day. To assure that there are no disruptions in your prescription, please allow two day notice on refills. Prescriptions for controlled substances or those that require prior authorizations may require more time to process. Please no after hours or weekend refill requests.

COMMUNICATION WITH YOUR PHYSICIAN:
If you have questions about your care or need to speak with the physician or physician's staff, we encourage our patients to contact their healthcare team via Mychart. If you need a Mychart activation code please call 713-798-6928 or email mychart@bcm.edu. If you are experiencing an urgent, health-related problem, do not attempt to use MyChart to communicate with your healthcare team. Please call 911 or your physician's office immediately at 713-798-5900.

Additional Information you may need:
Billing Department Number: 713-798-1900
Mychart Assistance: 713-798-6928
Mychart website: https://mychart.bcm.edu/MyChart/
Baylor Diagnostic Services: 713-798-2300
St Luke's Diagnostic Services: 832-355-0000

Patient Name _____ **Date**_____

Date of Birth _____ **Social Security Number** _____

Address _____

Phone (home) _____**Phone (work)** _____ **Phone (cell)** _____

Email: _____

Preferred Method for Receiving Appointment Reminders (circle one): Email Phone Text

Are you: Single Married Divorced Widowed

Do you have children? Yes No If yes, how many and how old? _____

Are you presently employed? Yes No **Grade level of education** (last year completed) _____

Occupation: _____

Year of retirement (if applicable) _____ **Year disabled** (if applicable) _____

Primary Care Physician (PCP) _____

Address _____

Phone _____ **Fax** _____

Referring Physician _____

Address _____

Phone _____ **Fax**_____

Do you give the Department of Otolaryngology permission to contact your primary care physician, and the referring physician concerning your care? (Please circle one) Yes No

Preferred Pharmacy Name: _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone number: _____ **Fax number:** _____

What is the problem for which you are being seen (chief complaint)?

_____

_____

What tests have you previously had performed?

_____

_____

Name_____ **Date**_____

PAST MEDICAL HISTORY Please list all medical problems (active and past).

Active Medical Problems	Old Medical Problems

Have you seen other physicians for this problem? (Please List)

_____
_____
_____

MEDICATIONS Please list all medications (Prescriptions, Non-prescriptions, Alternative/ Supplements/Vitamins, birth control tablets, etc.) Please state the dose you are taking and how often.

Have you used recreational drugs? Yes No

If yes, what drugs and for what time frame? _____

_____

Do you regularly exercise? Yes No

If yes, what type and how often? _____

Are you on any type of special diet? Yes No

If yes, what type? _____

Name_____ **Date**_____

FAMILY HISTORY **( ) Adopted/I do not know my family history.**

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Anesthesia Problems							
Bleeding Disorder							
Clotting Disorder							
Hearing Loss							
Heart Disease							
Cancer (what type?)							
Thyroid disease							
Other (Specify)							

Please review the list of symptoms and circle "Yes" if you had any of these symptoms. Please circle "No" if you have not experienced any of the symptoms.

Constitutional

Yes No Fever/chills/sweats
Yes No Weight loss
Yes No Tiredness/fatigue
Yes No Night Sweats

Eyes

Yes No Reduced vision or blurriness
Yes No Double vison
Yes No Droopy eye lids

Endocrine

Yes No Hot/Cold intolerance

Cardiovascular

Yes No Chest pain/angina
Yes No Palpitations

Ear/Mouth/Throat/Nose

Yes No Ringing in the ears
Yes No Ear Pain
Yes No Otorrhea (ear drainage)
Yes No Vertigo

Allergic/Immunologic

Yes No Skin Allergies/Rashes
Yes No Frequent Infections

Respiratory

Yes No Cough
Yes No Phlegm
Yes No Coughing up blood
Yes No Wheezing

Psychiatric

Yes No Psychological
Yes No Hallucinations
Yes No Suicidal thoughts

Hematologic/Lymphatic

Yes No Easy Bruising
Yes No Enlarged Lymph nodes

Neurologic

Yes No Muscle weakness
Yes No Numbness or tingling

Yes No Swallowing problems
Yes No Dysphagia (trouble swallowing)
Yes No Hoarseness
Yes No Snoring

Yes No Food Allergies

Musculoskeletal

Yes No Neck pain
Yes No Back pain
Yes No Muscle pain
Yes No Swelling of joint

Skin

Yes No Rash
Yes No Change in sweating
Yes No Burns

Genitourinary

Yes No Urinary Frequency
Yes No Nocturia

Gastrointestinal

Yes No Abdominal pain
Yes No Nausea/ vomiting

Yes No Nasal drainage
Yes No Sinus pain
Yes No Nasal obstruction
Yes No Nose Bleeds

New Patient
General Intake Form

BCM has developed this **General Intake Form**, which is common to all of our offices. Your answers will be accessible at any future BCM office visit in your electronic chart. To provide additional information important to your appointment today, each department has created a **Specialty Intake Form** with questions specific to their department, so please ensure you fill this out as well.

Patient Name _____ Date of Birth _____ Today's Date _____

ALLERGIES Please list any allergies or reactions to medication(s):

_____

_____

MEDICAL HISTORY Please check the boxes to indicate if you have had any of these conditions:

☐ NONE	☐ Cirrhosis	☐ Kidney Stone
☐ Abnormal Pap	☐ Colon Cancer	☐ Memory Loss
☐ Alcohol abuse	☐ COPD/Emphysema	☐ Migraine/Headaches
☐ Allergies, Seasonal	☐ Crohn's Disease	☐ Osteoporosis
☐ Anemia	☐ Depression	☐ Peripheral Artery Disease
☐ Anxiety	☐ Diabetes	☐ Prostate Cancer
☐ Arthritis	☐ Diverticulitis	☐ Prostate Problem
☐ Asthma	☐ Glaucoma	☐ Reflux or GERD
☐ Autoimmune Disorder	☐ Hearing Loss	☐ Seizure Disorder
☐ Bleeding Disorder	☐ Heart Attack	☐ Skin Cancer
☐ Blood Transfusions	☐ Hepatitis	☐ Stroke
☐ Blood Clots/ DVT	☐ High Cholesterol	☐ Thyroid Problem
☐ Breast Cancer	☐ High Blood Pressure	☐ Transient Ischemic Attack
☐ Breast Lump	☐ HIV	☐ Ulcers of Stomach
☐ Carotid Artery Disease	☐ Irregular Heartbeat	☐ UTIs – Recurrent
☐ Cataracts	☐ IV Drug Use	☐ Valve Problem /Murmur
☐ Cervical Cancer	☐ Kidney Disease	☐ Varicose Veins/Phlebitis

Please specify any other medical condition(s) that you have now or have had in the past:

_____

_____

_____

SURGICAL HISTORY

Please use the space below to explain your past surgical procedures with dates (including cataract surgery, biopsies and any skin procedures).

_____

_____

_____

FAMILY HISTORY Please write in any IMMEDIATE family member (i.e. mother) who has or has had the following conditions in the space provided. Include their age when first diagnosed.

Check here ☐ if you were ADOPTED

Condition	Family Member	Age	Condition	Family Member	Age
Breast Cancer			CVA/Stroke		
Colon Cancer			Diabetes		
Ovarian Cancer			High Cholesterol		
Prostate Cancer			High Blood Pressure		
Melanoma			Other		
Depression					
Heart Attack/Bypass					

LIFESTYLE CHOICES

Tobacco

Do you smoke? ☐ Yes ☐ No ☐ Quit

Do you use smokeless tobacco? ☐ Yes ☐ No ☐ Quit

How many years? _____

How many packs/cans per day? _____

Are you ready to quit? ☐ Yes ☐ No

If you quit using tobacco, when did you stop? _____

Alcohol

Do you consume alcohol? ☐ Yes ☐ No ☐ Quit

How many drinks containing alcohol do you consume in a week? _____

(1 drink = 1 glass of wine = 1 can of beer = 1 shot of liquor)

Please also complete the **Specialty Intake Form** for this office.

Thank you for choosing Baylor College of Medicine.

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THE BOBBY R. ALFORD, MD
DEPARTMENT OF OTOLARYNGOLOGY-
HEAD AND NECK SURGERY

Welcome to our practice. We appreciate the confidence and trust that you place in us. Our office is focused on providing you with high quality care. To that end patients coming to our physicians may require additional services for a thorough evaluation of their condition.

Please consult with your physician during your visit for any specific questions regarding these services, which may include:

- **Fiber optic exam of nasal passages, sinus cavities or throat and vocal cords (endoscopy or laryngoscopy)**
- **Audiology (hearing) testing**
- **Speech therapy**
- **Epley maneuver**
- **Cerumen removal**

PLEASE NOTE: The procedures above, and many other procedures performed in the clinic, are additional services that are categorized as "surgical procedures" by the insurance industry.

Fees for these additional services are submitted to your insurance company as separate item(s) **in addition to the office visit charges**. If your insurance covers these services, you will be obligated to pay any deductible, coinsurance or copay amounts. In the event that services are not covered by your insurance, you will be responsible for the fees associated with the services.

Please discuss any concerns about the services with your healthcare provider. We also have staff in our practice with billing expertise who can answer further questions.

Thank you for choosing our practice. We look forward to participating in your healthcare needs.

_____ _____
Signature of patient or legal guardian DOB

_____ _____
Print name of patient Date