HOUSTON Methodist LEADING MEDICINE

Eugene L. Alford, MD, FACS
Director

Houston Methodist ENT & Facial Plastic Surgery
Scurlock Tower
6560 Fannin, Suite 704
Houston, Texas 77030-2735
Appointments: 713-532-FACE (3223)
Facsimile: 713-799-8821

Patient Information and Demographics Today's Date:_____

*****ALL BLANKS MUST BE COMPLETED PRIOR TO VISIT*****

Patient name:_____ Date of Birth:_____
First Middle Initial Last

Address:_____
Street and Apartment # City State Zip Code

SS#:_____ **Gender**: Male or Female **Primary Care Phys Name:** _____

Home Phone:_____ **Cell Phone:**_____**Other:** _____

Email: _____ Any restrictions for contacting you? Y or N

Preferred Pharmacy Name & Address:_____ Phone Number:_____

Patient's Employer:_____ Occupation:_____
Work phone number: _____

Emergency Contact
Name:_____ Relationship:_____
Phone number:_____

If patient is a minor
Name of legal guardian:_____
Home phone:_____ work phone:_____

How did you hear about Dr. Alford:
Friend/Relative: _____ Referral by Doctor:_____ Website:_____ Other:_____

Insurance holder's relationship to patient:_____ or □Self
Insurance holder's Name:_____ Date of Birth:_____
SS#:_____ Employer:_____
Phone Number:_____ Alternate phone:_____
Address (if not same as patient):_____
Street and Apartment # City State Zip Code

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient or Guardian Date

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Medical Information and History

Name:_____DOB:_____ Age:_____ Height:____ Weight:_____ Date:_____

History of Present Illness
Why are you seeing the doctor today:_____
Has any other physician treated you for this problem?_____
Is this problem the result of an injury or accident: If Yes please give date and details of injury/accident: **Y or N**
_____

Past Medical History (please list all medical conditions including date of diagnosis or hospitalization):

_____ _____
_____ _____
_____ _____

Previous Surgery	Date	Surgeon

Please list all implants, pacemakers, artificial joints and/or metal in the body:
_____
_____

Medications (please include all prescriptions, OTC and herbal supplements)

Name of Medication	Dosage	Frequency	Indication

Do you take any blood thinners: Y or N □Aspirin □Coumadin □Anti Inflammatory medications: _____
Drug Allergies and type of reaction: □None □Penicillin □Codeine □Other: _____
Inhalant/Environmental Allergies: Y or N **Do you take allergy shots?** Y or N
Food Allergies: Y or N _____

Other Health History

Occupation: _____

Marital Status: _____ No. of Children: _____

History of family illnesses (please list relation, medical condition and age)

_____

_____

Alcohol use (describe type & amount): _____

Never Occasionally Daily Weekly

Tobacco use (describe type & amount): type: _____ packs per day: _____ number of years: _____ quit date: _____

Never Occasionally Daily Weekly

Special Diet (describe type & amount): _____

Never Occasionally Daily Weekly

Exercise (describe type & amount): _____

Never Occasionally Daily Weekly

Do you get fever blisters: Y or N

Is there any other medical information you feel we should be aware of?: _____

_____

_____

_____

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_____ _____

Signature of Patient or Guardian Date

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Patient Communication Consent Form

I authorize *Houston Methodist ENT & Facial Plastic Surgery* and staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below:

Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date
Name	Relationship to Patient	Date

Signature of Patient/Parent or Guardian

Date