South Coast Ear, Nose & Throat
Charles G. Hurbis, M.D., F.A.C.S.
2695 N. 17th Street, Coos Bay, OR 97420
Phone (541) 266-0900

Dear Patient:

We are pleased to welcome you to our medical practice and appreciate the opportunity to provide you with your healthcare needs. We take pride in and are committed to providing you quality healthcare in a comfortable and professional environment.

Enclosed you will find a medical history form and a patient information form. Please **complete the enclosed forms and bring them to your appointment** with you. Include a complete list of medications and supplements that you are presently taking. If you have medical insurance, please **bring your insurance card(s)** with you to your appointment as well.

Some reminders about your medical insurance:

- We bill your insurance as a courtesy.
- Providing us with a copy of your insurance card(s) allows us to bill for your services correctly.
- Some insurance policies require a referral. Please let us know prior to the day of your appointment if your insurance requires a referral.

If you have any questions regarding our services or need to reschedule your appointment, please contact our office at (541) 266-0900. Thank you for choosing South Coast Ear, Nose & Throat. We look forward to meeting you.

Sincerely,
Dr. Hurbis and Staff

Enclosures: Medical History Form
Patient Information Form

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PATIENT INFORMATION

If you need help with this form, please ask for assistance.

PATIENT

Name_____ Date_____
First Middle Last

SSN_____ Birth Date_____ ODL No._____

Have you been seen under a different last name? □No □Yes If yes, what name?_____

Address_____

City_____ State_____ Zip _____ Home Phone_____

Email Address_____ Work Phone_____

Who requested that you visit this office? □Referring Doctor _____
□Emergency Room □Self-Referral □Family
□Advertisement □Coach/Trainer □Friend

Employer_____
Address _____ City_____ State_____ Zip_____
Spouse's Name_____ Emergency Contact_____

CHIEF COMPLAINT

What are you being seen for today?_____

RESPONSIBLE PARTY □Self □Spouse □Parent

_____
Name of Responsible Party Address

_____
Social Security No. Birth Date Home Phone Work Phone

_____
Employed By Occupation Length of Employment

MEDICAL INSURANCE INFORMATION **If you have no medical insurance, check here** □
Today's visit will be billed to: □Regular Medical Insurance □Self-Pay □Work comp/Liability

_____
Primary Insurance Co. Mailing Address

_____
ID No. Name of Insured DOB Phone

_____
Secondary Insurance Co. Mailing Address

_____
ID No. Name of Insured DOB Phone

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MEDICAL HISTORY

If you need help with this form, please ask for assistance

Name_____Age_____Height_____Weight_____

ALLERGIES: Please check any medications to which you have had a bad reaction and describe the reaction.

☐penicillin ☐sulfa ☐aspirin ☐iodine-dye ☐iodine-on-the-skin ☐tetanus-antitoxin

☐latex ☐morphine ☐codeine ☐other medications and reactions to them:_____

_____

_____

Soap, tape, or food allergies? (please list):_____

_____

MEDICATIONS: Please list the names, dosages and frequencies of all prescription medicines you are now taking or have taken within the past month:

Drug Name:_____ Dosage:_____ Times taken per day:_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PREVIOUS OPERATIONS: Please list any major operations you have had and either the date or your age.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

MEDICAL ILLNESSES: Please check any serious medical illnesses you have or have had.

☐heart disease ☐high blood pressure ☐heart attack ☐heart failure ☐asthma ☐TB

☐lung disease ☐diabetes ☐cancer ☐liver disease ☐hepatitis ☐thyroid disease ☐stroke

☐stomach ☐ulcer ☐hiatal hernia ☐inherited disease ☐kidney disease ☐heartburn ☐epilepsy

☐other:_____

FAMILY HISTORY: For living parents, please list their ages and state of health; if deceased, please note their cause of death and age at death.

	Age	Living	State of Health/Cause of Death
Mother	_____	☐yes ☐no	☐good ☐fair ☐ poor /_____
Father	_____	☐yes ☐ no	☐good ☐fair ☐poor / _____

Please list any health problems of your brothers or sisters:_____

_____

Please continue to page two →

PERSONAL HABITS:

Do you smoke cigarettes? □yes □no If yes, ____ packs per day. If you stopped, when did you? _____

Do you drink alcohol? □yes □no If yes, how much?_____. If you stopped, when? _____

SYSTEMS REVIEW: Please check any of the following if you have had or now are having them.

General: □fever □chills □night sweats □unexplained weight loss □"cold" or flu

Head, Eyes, Ears, Nose & Throat: □decreased hearing or vision □glasses □ contact lenses □ringing in ears □dizziness or vertigo □sinus trouble □repeated nose bleeds □dentures □loose, false or capped teeth

Heart & Lungs: □heart disease □high blood pressure □chest pain □wheezing □heart failure □heart surgery

□palpitations (skipping heart beat) □swelling of feet or ankles □heart surgery □chronic cough □asthma □lung disease □shortness of breath □coughing up blood □tuberculosis

Gastrointestinal: □abdominal pain □stomach ulcer □diarrhea □nausea □constipation □vomiting □bloody or tarry-black colored stools □severe heartburn □hiatal hernia □liver disease □jaundice □hepatitis

Kidneys & Bladder: □kidney disease □pain or burning with urination □difficulty starting urinary stream □frequent night urination □bloody urine

Reproductive (For women): □menstrual problems Are you pregnant? □ yes □no

Nervous System: □severe emotional/mental problems □numbness □passing out □epilepsy □convulsions □family history of nerve or muscle disease □stroke □personal or family history of malignant hyperthermia

Musculoskeletal System: □rheumatoid arthritis □other forms of arthritis □gout □TMJ problems □sciatica □neck or spine trouble

ANESTHETIC HISTORY: Have you had a problem with a past anesthetic? □yes □no

Have family members had an anesthetic related problem? □yes □no

Do you wish to discuss anesthetic risks with the Anesthesiologist? □yes □no

PATIENT SIGNATURE:_____

DATE FORM COMPLETED:_____

Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Dr. Charles Hurbis of South Coast Ear, Nose & Throat to furnish the insured's insurance company all information that they may request. This authorization extends to all treating physicians.

I hereby assign to Dr. Charles Hurbis of South Coast Ear, Nose & Throat all insurance proceeds to which he is entitled for medical and/or surgical expenses relative to services performed from time to time, but not to exceed my indebtedness to the said physician and surgeon. I understand that this assignment does not relieve me from responsibility for charges not paid by the insurance company.

If you are a *Foster Parent,* you are required to sign this for Dr. Hurbis to treat and bill the patient's insurance, on behalf of the patient.
You are not responsible financially for payment of services rendered.

Patient /Guardian / Foster Parent PRINT NAME Date

Patient / Guardian / Foster Parent SIGNATURE Date

Form updated: 12-11-14