

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
Website: churbismd-scent.com

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.

high blood pressure heart attack heart failure stroke asthma TB lung disease (COPD/Asthma)
 diabetes thyroid disease liver disease hepatitis A/B/C HIV/AIDS stomach heartburn ulcer
 hiatal hernia kidney disease epilepsy cancer, type: _____ inherited disease
 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.

<u>Age</u>	<u>Living</u>	<u>State of Health/Cause of Death</u>
Mother _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor / _____
Father _____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> 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 quit, when? ____ packs per day? __

Do you use chewing tobacco? yes no If yes, ____ cans per week. If you quit, when? ____ cans? ____

Do you drink alcohol?yes no If yes, how much?_____ If you stopped, when? ____how much? ____

Do you use marijuana? yes no If yes, how much and what form?_____ If you quit, 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 surgery heart disease high blood pressure chest pain wheezing heart failure
palpitations (skipping heart beat) swelling of feet or ankles 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 A/B/C

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:_____

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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 PRINT NAME **Date**

Patient / Guardian SIGNATURE **Date**