

PATIENT NAME: _____

PERSONAL PHYSICIAN: _____

REFERRED BY: _____

PERSONAL PHARMACY: _____

Please complete the following questions

What medical problems may we help you with today?

Medicine allergies (please include reaction):

What medicines are you taking (include prescription and over-the-counter drugs)?

What medical problems do you regularly see your doctor for (such as high blood pressure, heart disease, etc.)?

What surgeries have you had? _____

Please list non-surgical hospitalizations _____

Please list diseases that run in the family (such as heart disease, cancer, allergies, etc.) _____

Current occupation: _____

What hobbies or interests do you have? _____

Religious affiliation: _____

Do you use tobacco products? YES / NO If yes, what form, how many years, and how much per day?

Do you drink alcohol? YES / NO If YES, how many drinks per week? _____

Dear patient,

Your health status is important to us. Please circle any of the following signs or symptoms you may have.

GENERAL - fevers, chills, sweats, weight loss, weight gain

SKIN - itching, bruising, bleeding, non-healing sores, pigmentation change

MUSCULOSKELETAL - arthritis, muscle inflammation, joint swelling, joint stiffness, muscle weakness

ENDOCRINE SYSTEM - weakness, goiter, skin or hair dryness, heat or cold intolerance, excessive appetite / drinking / urination

ALLERGY / IMMUNOLOGY- dermatitis, hives, eczema, asthma, hay fever

HEAD / NECK - headache, migraine, seizures, fainting, visual loss, double vision, deafness, vertigo, ear drainage, ear pain, nasal drainage, nasal blockage hoarseness, neck stiffness / pain

RESPIRATORY SYSTEM - painful breathing, shortness of breath, wheezing, awakening short of breath, cough, sputum or blood with coughing

CARDIOVASCULAR SYSTEM - palpitations, fast heart rate, irregular heart rate, chest pain, leg swelling, leg pain with exercise / sleeping

GASTROINTESTINAL SYSTEM - swallowing problems, nausea, vomiting, abdominal pain, jaundice, rectal bleeding, black or bloody stools

GENITOURINARY SYSTEM – change in urine color, painful urination, bloody urine, frequent urination, incontinence, stones

NERVOUS SYSTEM – paralysis, incoordination, difficulty speaking, numbness, tingling, staggering, vision changes

Date of completion: _____

Signature of Patient: _____

ADVANCED OTOLARYNGOLOGY, P.C.
Mark C. Loury, M.D., F.A.C.S.
Steve B. Schaffer, M.D.
2001 S. Shields, Bldg. E, Suite 101
Fort Collins, CO 80526
(970) 493-5334

PATIENT INFORMATION:

DATE: _____

Last Name First Name Middle

Soc. Sec. # Date of Birth Age M/F
Sex

Street Address Apt. # City State Zip

(_____) _____
Home Phone Marital Status

Employer Employer's Address (_____) Business Phone

IF PATIENT IS A CHILD PLEASE GIVE PARENT'S / GUARDIAN'S NAME:

Mother Father Guardian

EMERGENCY NOTIFICATION – IN CASE OF EMERGENCY PLEASE NOTIFY:

Guardian, Relative or Friend Relationship (_____) Phone

Address City State Zip

INSURED INFORMATION – PERSON RESPONSIBLE FOR ACCOUNT

Name Address Apt. # City State Zip

(_____) _____
Home Phone Occupation (_____) Business Phone

Employer Address Apt. # City State Zip

Soc. Sec. # Date of Birth Relationship to Patient

Insurance Information

Name of Insurance: _____

Address of insurance: _____

Name of Policy Holder: _____

Social Security No. for Policy Holder: _____

Date of Birth for Policy Holder: ____ / ____ / ____

Patient's Name: _____

Private Insurance Company:

I hereby instruct the insurance company listed above to pay benefits directly to **ADVANCED OTOLARYNGOLOGY, P.C.** and/or Mark C. Loury, MD, 2001 S. Shields St. Suite E-101, Fort Collins, CO, 80526-1827

HMO and Group Insurance:

Should there be a referral required through an HMO or Group Insurance plan that has not been obtained, I agree to pay in full any charges incurred.

Medicare:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in **Advanced Otolaryngology, P.C.**, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize the release of any information to any insurance company, adjuster, or attorney involved.

Financial:

I understand that payment for all services is my responsibility and agree to pay any balance over and above the insurance payment.

Signature of Policy Holder

Witness

Signature, if Patient is other than Policy Holder

____ / ____ / ____
Date

WE MUST RECEIVE A COPY OF YOUR
INSURANCE CARD WITHIN 24 HOURS OF TREATMENT
OR YOU WILL BE HELD FINANCIALLY
RESPONSIBLE FOR YOUR ACCOUNT!

ADVANCED OTOLARYNGOLOGY
2001 S. SHIELDS, E 101
FORT COLLINS, CO 80526
(970) 493-5334

I, _____ give permission for the following people to receive
(please print name)

medical information and/or to schedule appointments for surgeries and follow-up examinations.

1. _____

2. _____

Signature

Date _____ To _____