

PATIENT NAME: \_\_\_\_\_

PERSONAL PHYSICIAN: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

PERSONAL PHARMACY: \_\_\_\_\_

Please complete the following questions

What medical problems may we help you with today?

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Medicine allergies (please include reaction):

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

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

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What surgeries have you had? \_\_\_\_\_

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Please list non-surgical hospitalizations \_\_\_\_\_

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

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Current occupation: \_\_\_\_\_

What hobbies or interests do you have? \_\_\_\_\_

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Religious affiliation: \_\_\_\_\_

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

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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: \_\_\_\_\_



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!