



P.O. Box 6329
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Phone (541) 318-0858
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INSURANCE VERIFICATION

Patient Name _____ Procedure Date _____ Birth Date _____

Primary Insurance Co. _____

Insurance Co. Address _____

Subscriber ID _____ Group # _____

Subscriber Name _____ Birth Date _____ Employer _____

Secondary Insurance Co. _____

Insurance Co. Address _____

Subscriber ID _____ Group # _____

Subscriber Name _____ Birth Date _____ Employer _____

DATE OF PROCEDURE _____

PATIENT NAME _____ SURGEON _____ PRIMARY PHYSICIAN _____

REASON FOR ADMISSION _____ PROCEDURE _____

DOB _____ SEX _____ HEIGHT _____ WEIGHT _____ PHONE (home) _____ (work) _____ (cell) _____

PHONE # TO REACH YOU ON SURGERY DAY _____ PERSON DRIVING YOU HOME _____ PHONE _____

EMERGENCY CONTACT _____ LEARNING PREFERENCES WRITTEN VERBAL

MAY WE LEAVE A MESSAGE ON YOUR MACHINE? YES NO N/A IF YES, MAY WE LEAVE INFORMATION REGARDING YOUR MEDICAL PROCEDURE? YES NO

DO YOU HAVE A SIGNIFICANT HISTORY OR CURRENTLY HAVE:

YES NO

- Neuro**
- Seizures
 - Strokes
 - Black out spells
 - Numbness, weakness or paralysis

- Heart**
- Heart attack
 - Chest pains (angina)
 - Heart failure
 - Irregular heart beat; pacemaker
 - High blood pressure
 - Heart murmur, leaky valve

- Lung**
- Shortness of breath
 - Asthma or wheezing
 - Emphysema
 - Frequent bronchitis or pneumonia
 - Recent cold or infection
 - TB or other lung problems

YES NO

- Abdomen**
- Hiatal hernia or heart burn
 - Ulcer disease
 - Hepatitis
 - Kidney or urination problems
 - Other abdominal problems

- Misc.**
- Diabetes, thyroid or other gland problems
 - Anemia, bleeding or other blood problems
 - HIV disease
 - Artificial or limited movement joints

- Anesthesia**
- Problems with any prior anesthetics
 - Airway problems (snoring, sleep apnea, "difficult airway" at surgery)
 - Limited mouth opening or neck movement
 - Dental plates, loose / chip / capped teeth
 - Blood relatives with life threatening anesthesia problems
 - Motion sickness
 - Anxiety attacks or claustrophobia

Other medical problems or comments _____

Do you **smoke?** # _____ yrs smoked # _____ packs per day (If you are a former smoker, what year did you quit? _____)

Do you **drink** alcohol? _____ per day _____ per week

Do you use recreational **drugs?** _____

Do you have: Glasses, Contacts, Hearing aid(s), Physical aids (e.g., cane) _____

Implanted Cardiodefibrillator Implanted Metal YES NO

FEMALES: Date of your last normal period _____ **Hysterectomy** **Menopause**

Please list your previous operations _____

Please list medications you are taking with dosages and frequencies (include over-the-counter, herbals, etc.) _____

Do you have any **cultural / religious beliefs** that may affect our providing health care? N/A or Explain _____

Please list allergies you have, including tape, latex and food (include type of reaction such as rash, nausea, etc.) _____

PLEASE HAVE SOMEONE AVAILABLE TO CARE FOR YOU THE FIRST 24 HOURS AFTER SURGERY.

Patient Signature _____ Date _____

(Relationship if not patient _____)

X _____ (Nurse's Signature) R.N. _____ (Date) _____ (Time)

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