Shasta ENT Specialists
Redding SINUS Center
George H. Domb M.D.

NEW PATIENT MEDICAL INFORMATION SHEET

Patient Name:_____

Date:_____Birth Date:_____M/F:_____

Family Doctor:_____Referred By:_____

Reason for Your Visit:_____

PLEASE CHECK ANY CURRENT SYMPTOMS

1. Ears:
   - _____ Itchy
   - _____ Pain
   - _____ Drainage
   - _____ Hearing Loss
   - _____ Ringing
   - _____ Dizziness

2. Nose and Sinus:
   - _____ Runny Nose
   - _____ Post-Nasal Drip
   - _____ Stuffy or Congested
   - _____ Nosebleeds
   - _____ Problems with sense of smell
   - _____ Polyps

3. Mouth and Throat:
   - _____ Sore Throat
   - _____ Tonsillitis
   - _____ Mouth Breathing
   - _____ Problems Swallowing
   - _____ Hoarseness

4. Snoring:
   - _____ Yes _____No
   - _____ Daytime Sleepiness

5. Tobacco Use:

   Y/N_____Since_____Quit?_____When?_____Chew_____

   Cigarettes_____Packs/Day_____Pipe_____Cigar_____

6. Alcohol Use:

   Never_____Daily_____Weekly_____Social_____Quit?_____When_____

7. Allergies to Medications:

_____

_____

8. Medications you are now taking, including over –the – counter:

_____

_____

9. Medications you have taken in past(and way):

_____

_____

10. Do you take Blood Thinners? No_____ Yes_____
Plavix_____Aspirin_____Ibuprofen_____Persantine_____Coumadin_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING

Diabetes	_____	High Blood Pressure	_____
Hepatitis	_____	Asthma/Lung Problems	_____
Bleeding Tendency	_____	Thyroid Problems	_____
AIDS/HIV+	_____	Chest Pain/Stroke	_____
Ulcer	_____	Heart Attack/When?	_____
Prev. Ear Surgery	_____	Stroke	_____
Nose/Sinus Surgery	_____	Loud Noise Exposure	_____

11. Please List Any Prior Surgeries:

_____

_____

12. Ladies: Could You Be Pregnant? _____

Would you like Dr. Domb to know anything else about you?

_____

_____

_____

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

SHASTA ENT SPECIALISTS/REDDING SINUS CENTER
George H. Domb M.D.
Patient Registration

Today's Date: _____ Referred by: _____

Thank you for choosing our office. In order to serve you properly, we will need the following information. **PLEASE PRINT**. All information will be strictly confidential.

Name: _____ Sex: Male___ Female___

Home Address: _____ Social Security#_____

City:_____ST:_____ Zip:_____ Date of Birth:_____ Age___

Mailing Address: _____ DL# _____

Home Phone# _____ Cell#_____ E-Mail Address:_____

Preferred method of communication Home Cell Email

Employer: _____ Occupation: _____

Address: _____City:_____ST:_____Zip:_____

Business Phone #_____

If Patient is a minor…

Parent/Legal Custodian Name:_____ Home Phone#_____

Home Address:_____City:_____ST:_____Zip:_____

Primary Insurance Information

Insured's Name: _____
Relationship to Patient Self Spouse Parent

Insured Social Security #_____

Insured's Birth Date:_____

Insurance Company Name_____

Policy #_____Group#_____

Secondary Insurance Information

Insured's Name: _____
Relationship to Patient Self Spouse Parent

Insured Social Security #_____

Insured's Birth Date:_____

Insurance Company Name_____

Policy #_____Group#_____

Emergency Information

Emergency Contact:_____ Relationship:_____Phone# _____

I assign directly to Dr. George H. Domb any insurance benefits payable for services rendered. I understand that I am financially responsible for all charges whether paid by my insurance or not. I authorize the release of information necessary to secure the payment of benefits.

_____
Signature of Patient/Guardian