ENT specialists, p.c.

Ear, Nose, Throat • Head and Neck Surgery • Otology • Allergy • Hearing Aids • Facial Plastics • Audiology

Patient's Name: _____

Social Security: _____

Today's Date: _____

Family Physician (Pediatrician): _____

Office Location (City Only): _____

Pharmacy(with location): _____

Employer: _____

Please Tell Us How You Found Our Practice

Check (√) those that apply:

- ☐ Physician Referral (who?):
- ☐ Family Member or Friend
- ☐ Advertisement
  - ☐ Newspaper
  - ☐ Marketeer
  - ☐ Yellowpages
- ☐ Hearing Aid Dealer
- ☐ Other (Please Explain):
- ☐ Internet
  - ☐ Google Search
  - ☐ Yahoo Search
  - ☐ Microsoft / Bing
  - ☐ Insurance Web Site
  - ☐ Yellowpages.com

COMMUNICATIONS REQUEST

We would like to request your points of contact. This information will be used *only* for future communications directly from ENT Specialists, such as appointment reminders. Your information will be kept strictly confidential and will not be given to any third party. Please fill in all applicable fields.

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

PAYMENT AND CANCELLATION POLICY

We would like to remind you that payment for services received is due upon the day of service. We appreciate your cooperation when collecting insurance co-payments or deductibles *prior* to your visit with the physician. If you are unable to make payment on the day of service, we would like to inform you that it is our policy to add a $10 surcharge for any billing statements sent to collect on co-payments. This is to recuperate costs associated with processing, sending, and filing these statements.

If you are unable to keep an appointment, please call the office and give proper notification that you will be unable to do so. If you are unable to keep your appointment, please call the office within 24 hours to cancel. If you do not give us appropriate notification, you will be charged a $25 no-show fee. This must be paid in full before your next visit. This is in an effort to allow other patients the opportunity to schedule an office visit with our physicians. We understand urgent situations may arise preventing you from keeping your appointment, we only ask for the courtesy of a phone call as soon as possible.

Thank you,
ENT Specialists, P.C.

Patient/Responsible Party Signature: _____

28080 Grand River
Suite 208
Farmington Hills, MI 48336
(248) 477-7020
Fax (248) 477-2440

25500 Meadowbrook Rd
Suite 220
Novi, MI 48375
(248) 477-7020
Fax (248) 477-2440

www.entspecialistspc.com

7575 Grand River
Suite 110
Brighton, MI 48114
(810) 844-7680
Fax (810) 844-7684

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REVIEW OF GENERAL MEDICAL SYSTEMS

Check (√) either YES or NO for each Item

Patient's Name:_____

	YES	NO
GENERAL		
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Weight Loss	☐	☐
General Weakness	☐	☐
Bruise Easily	☐	☐
Memory Loss	☐	☐
Swollen Glands	☐	☐
EYES		
Blurry Vision	☐	☐
Double Vision	☐	☐
Halos	☐	☐
Light Flashes	☐	☐
EARS		
Hearing Loss	☐	☐
Ear Pain	☐	☐
Ear Drainage	☐	☐
Buzzing / Ringing	☐	☐
NOSE & THROAT		
Sinus Problems	☐	☐
Nosebleeds	☐	☐
Swallowing Problems	☐	☐
Persistent Hoarseness	☐	☐
Cough	☐	☐
Dental Pain	☐	☐
Mouth Sores	☐	☐
Loss of Taste / Smell	☐	☐
KIDNEY		
Blood in Urine	☐	☐
Pain while Urinating	☐	☐
Difficulty Urinating	☐	☐
Frequent Urination	☐	☐
NEUROMUSCULAR		
Leg or Arm Weakness	☐	☐
Dizziness	☐	☐
Balance Problems	☐	☐
Fainting Spells	☐	☐
Headaches	☐	☐
Speech Problems	☐	☐

	YES	NO
SKIN		
Rash	☐	☐
Changing Moles	☐	☐
Pigmentation	☐	☐
HEART & LUNGS		
Irregular Heartbeat	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Frequent Cough	☐	☐
Coughing Blood	☐	☐
Chest Pains	☐	☐
Swollen Ankles	☐	☐
BONES		
Joint Pain	☐	☐
Joint Swelling	☐	☐
NECK		
Stiffness	☐	☐
Swelling	☐	☐
Lumps / Bumps	☐	☐
GASTROINTESTINAL		
Poor Appetite	☐	☐
Indigestion / Heartburn	☐	☐
Nausea / Vomiting	☐	☐
Vomiting Blood	☐	☐
Abdominal Pain or Cramps	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in Stool	☐	☐
ENDOCRINE		
Constant Thirst	☐	☐
Always Feel Warm	☐	☐
Always Feel Cold	☐	☐
Often Feel Depressed	☐	☐
SLEEP		
Fall Asleep Easily	☐	☐
Awaken Easily	☐	☐
Snoring	☐	☐
Stop Breathing at Night	☐	☐
Feel Sleepy throughout the Day	☐	☐
Fall Asleep at Work	☐	☐

I have reviewed the above Review of Systems. Physician's Signature:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices. This notice describes the use and disclosure of my protected health information and rights I have regarding my protected health information. Additional copies are available at the front desk, on our website at www.entspecialistspc.com, or upon further request by mail.

Print Name	Signature	Date
Relationship if Patient is Under Age 18		

According to the Notice of Privacy Practices, we may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Please note the name and relationship to the patient of those you give us permission to disclose medical information:

Legal Last Name	First Name	Relationship to Patient
Legal Last Name	First Name	Relationship to Patient
Legal Last Name	First Name	Relationship to Patient

INSURANCE AUTHORIZATION

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. **It is your responsibility to know your individual coverage.** Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember your insurance policy is between you and your company and not with the insurance company and your doctor.

ENT Specialists PC is hereby authorized to give my insurance company or its representative, any and all information they may have regarding my or my dependent's condition when under observation or treatment by them, including history obtained, diagnosis and treatment. A photocopy of my signature may be used. I hereby assign the benefits payable under my insurance to ENT Specialists PC for any services provided. I authorize all medical information about me to be released to the Health Care Financing Administration and its agents to determine these benefits or the benefits payable for related services.

I herby authorize release of any information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Print Name	Signature	Date

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the HEARING center at ENT specialists, p.c.

HEARING CENTER PATIENT INFORMATION SHEET

Patient:_____
Spouse:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Social Security #:_____
Age:_____Birthdate:_____Male:_____Female:_____
How did you hear about us?_____

_____

Will this be your first hearing test?_____
Have you been examined by a doctor in the past 6 months?_____
Have you ever had ear surgery?_____
Has the hearing in one ear rapidly decreased within the previous 90 days?_____
Have you experienced acute or recurring dizziness?_____
In which ear is your hearing impaired? Left?_____ Right?_____ Same?_____
Do you know the cause of your hearing loss?_____
Cause? _____
Are you experiencing ear pain? _____
Have you noticed any change in your ability to remember?_____
Do you have ringing of the ear?_____
Do you sometimes hear conversation loud enough but cannot understand the words?_____
Do you often ask others to repeat?_____
Do you find it difficult to understand conversation in noise?_____
Do you have trouble hearing on the telephone?_____
Do you have difficulty hearing your spouse?_____
Do others mention you play the radio or TV too loudly?_____
What comments have others made about your hearing?_____
In what situation do you have the most difficulty understanding?_____
If hearing loss is discovered, are you ready for help?_____

I wear a hearing aid in my Left Ear, Right Ear, Both ears (circle one), but still experience the following problems:

_____Some sounds are too loud
_____Everything sounds tinny
_____The hearing aid whistles
_____Wind noises bother me
_____My voice sounds hollow and unnatural
_____I have trouble understanding when two or more are talking
_____I can't tell from which directions sounds are coming
_____ My ears feel plugged
_____Telephone use is difficult for me

MEDICAL WAIVER

I have been advised by The Hearing Center at ENT Specialists, P.C. that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably who specializes in diseases of the ear) before purchasing a hearing aid. The use of a hearing aid cannot restore hearing to normal. Improvement is based on duration and severity of impairment.

I am at least 18 years of age.

_____ I do not wish to obtain a medical evaluation prior to purchasing a hearing aid.

Signature:_____ Date:_____

the HEARING center at ENT specialists, p.c.

HIPAA

Authorization for the Use or Disclosure of Protected Heatlh Information

I consent to the use or disclosure of my personal health informtion (including audiograms) by _____("Provider") for the purpose of diagnosing or providing hearing care and treatment to me.

I understand that diagnosis or treatment of me by Provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out hearing care and treatment. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this consent.

My "protected health information" ("PHI") means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to Provider's use or disclosure of my PHI for purpose of delivering relevant product and/or technology marketing communications to me. I acknowledge that Provider may receive financial remuneration from the manufacturer in connection with such communications.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority