Ear, Nose & Throat Consultants
QUALITY HEARING AID CENTER
THE SINUS CENTER *OF GREATER DETROIT*

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Comprehensive History Evaluation

Patient Name _____ Date _____
Please Print

Please complete the following medical history form. This will assist your physician in making your diagnosis and instituting your treatment.

Ear Problems	Nose Problems	Throat Problems
☐ Hearing Loss	☐ Blocked	☐ Sore Throat
☐ Dizziness	☐ Drainage	☐ Difficulty Swallowing
☐ Ringing or Other Noise	☐ Bleeding	☐ Voice Change-Hoarseness
☐ Drainage	☐ Sneezing	☐ Cough
☐ Pain	☐ Loss of Smell	☐ Sleep Apnea
☐ Other _____	☐ Facial Pain	☐ Snoring
	☐ Other _____	☐ Thyroid
		☐ Other _____

Which of the above is the main problem? ☐ Ears ☐ Nose ☐ Throat

Present Medical Illnesses: _____

Present Medications: _____

Present Allergies to Medication(s) (please indicate if your reaction was a rash, breathing difficulty, etc.): _____

PAST MEDICAL HISTORY AND SYSTEM REVIEW

Injuries: _____

Past Surgeries: _____

Hospitalizations: _____

Do you use alcohol? ☐ Yes ☐ No How much and for how long? _____

Do you smoke? ☐ Yes ☐ No How much and for how long? _____

METABOLIC

- Diabetes ☐ Yes ☐ No
- Blood Clots ☐ Yes ☐ No
- Bleeding Problems ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Thyroid Disorders ☐ Yes ☐ No
- Anesthesia Complications ☐ Yes ☐ No

HEART PROBLEMS

- Myocardial Infarction (Heart Attack) ☐ Yes ☐ No
- Angina (Chest Pain) ☐ Yes ☐ No
- Arrhythmia (Skipped Beats) ☐ Yes ☐ No
- Heart Murmur ☐ Yes ☐ No
- Mitral Valve Prolapse ☐ Yes ☐ No
- High Blood Pressure (Hypertension) ☐ Yes ☐ No

LUNG PROBLEMS

- Emphysema / COPD ☐ Yes ☐ No
- Tuberculosis (T.B.) ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Shortness of Breath ☐ Yes ☐ No
- Pneumonia ☐ Yes ☐ No

INFECTIOUS DISEASES

- Herpes ☐ Yes ☐ No
- V.D. / Syphilis ☐ Yes ☐ No
- A.I.D.S. / H.I.V. ☐ Yes ☐ No
- Hepatitis (Jaundice) ☐ Yes ☐ No
- Polio ☐ Yes ☐ No
- Meningitis ☐ Yes ☐ No
- Infectious Mono ☐ Yes ☐ No *(When? _____)*
- Polio ☐ Yes ☐ No

NEUROLOGIC

- Strokes / C.V.A. ☐ Yes ☐ No
- Seizures / Convulsions ☐ Yes ☐ No
- Alterations in Vision *(Other than glasses or cataracts)* ☐ Yes ☐ No
- Psychiatric Disorders ☐ Yes ☐ No

GASTROINTESTINAL / RENAL

- Ulcers ☐ Yes ☐ No
- Vomiting Blood ☐ Yes ☐ No
- Abdominal Pain ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No
- Kidney / Bladder Infections ☐ Yes ☐ No

CANCERS / TUMORS (please describe)

_____

_____

FAMILY MEDICAL CONDITIONS

- Heart Problems ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- Lung Problems ☐ Yes ☐ No
- Anesthesia Complications ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No

X _____ _____

Patient Signature Date

We thank you for your assistance in the evaluation of your health!

AUTHORIZATION FOR DIRECTION OF PAYMENT
HIPAA CONFIDENTIALITY RELEASE

This practice takes reasonable precautions with information. We cannot, however, guarantee confidentiality. Please acknowledge that you have read and understand this.

I have received, read and understand the Notice of Privacy Practices provided to me and which contains a more complete description of the uses and disclosures of my health information. I understand that Ear, Nose & Throat Consultants, P.C. has the right to change its Notice of Privacy Practices from time to time and that I may contact Ear, Nose & Throat Consultants, P.C. at any time at 29201 Telegraph Road, Suite 500, Southfield, MI 48034 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, or payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I hereby authorize my physician and/or staff to furnish information to insurance carriers concerning my illness and treatments. I authorize payments by insurance companies for medical benefits directly to:

EAR, NOSE & THROAT CONSULTANTS, P.C. and its physicians

FINANCIAL RESPONSIBILITY

All co-pays, deductibles, office visit fees and other charges are due at the time of your appointment. If we do not receive payment from your insurance company because of eligibility or premium payment issues, you (the patient or guardian) become financially responsible for our services.

I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes sixty (60) days past due a surcharge of thirty (30%) percent will be added to the delinquent amount.

If MEDICARE applies, then the following Medicare "ONE-TIME AUTHORIZATION AGREEMENT" also applies.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **EAR, NOSE & THROAT CONSULTANTS, P.C. and its physicians**, for any services furnished me by this provider.

I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, and its agents, any information needed to determine these benefits for related service.

PROCEDURE FEES

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carriers are classifying these procedures as "Surgery" and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not for a procedure. In such cases, payment for the procedure will be due from the patient or guardian. Be assured that we are following accepted billing and coding guidelines, and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

- Flexible Laryngoscopy: This procedure involves passing a long, thin, flexible fiber-optic scope through the nasal cavity and into the throat. The fiber-optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.
- Nasal Endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.
- Nasal Endoscopy with Debridement or Biopsy: This is the same procedure as above with removal of crusting or tissue.
- Some ear cleaning and hearing tests.

Please speak with our medical assistant if you have any questions.

I understand that I am responsible for my bill. I authorize EAR, NOSE AND THROAT CONSULTANTS, PC
to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to EAR, NOSE AND THROAT CONSULTANTS, PC. I authorize release of information necessary to collect any payments to all my insurance companies. I further authorize release of medical information to any and all physicians involved in my care. I permit a copy of this authorization to be used in place of the original. I authorize the use of the "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance.

PATIENT SIGNATURE:X_____ DATE:_____

I give my permission for _____, to discuss my medical care with the doctor**.**

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:_____Initials:_____Reason:_____

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PATIENT FOLLOW UP HISTORY & MEDICATION LIST

Patient Name_____ Date_____ Chart #_____

Past/Present History, Social History, Review of Systems & Allergies to Medications

❑ No Change Since Last Visit

Medications:

❑ Unknown

❑ No Change Since Last Visit

Present Medication Additions or Deletions Since Last Visit:

Prescriptions	Dosage	Frequency	Route of Administration

Over The Counter	Dosage	Frequency	Route of Administration

Vitamins Herbals	Dosage	Frequency	Route of Administration

Nutritional Supplements	Dosage	Frequency	Route of Administration

Signature X_____ Date_____