

Please Tell Us How You Found Our Practice

Check (✓) those that apply:

Patient's Name: _____

Today's Date: _____

Family Physician (Pediatrician): _____

Office Location (City Only): _____

- 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: _____

Work Phone: _____

Cell 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

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



Patient's Name: _____

REVIEW OF MEDICAL HISTORY

Check (✓) either YES or NO for each Item

	YES	NO		YES	NO		YES	NO
GENERAL			SKIN			KIDNEY		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Changing Moles	<input type="checkbox"/>	<input type="checkbox"/>	Pain while Urinating	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Pigmentation	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	HEART & LUNGS			Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
General Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	NEUROMUSCULAR		
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Leg or Arm Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	BONES			Speech Problems	<input type="checkbox"/>	<input type="checkbox"/>
Light Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
EARS			Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Constant Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	NECK			Always Feel Warm	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Always Feel Cold	<input type="checkbox"/>	<input type="checkbox"/>
Ear Drainage	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Often Feel Depressed	<input type="checkbox"/>	<input type="checkbox"/>
Buzzing / Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Lumps / Bumps	<input type="checkbox"/>	<input type="checkbox"/>	HABITS		
NOSE & THROAT			GASTROINTESTINAL			Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Do you Drink Coffee?	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion / Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Soda / Pop?	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	Do you Fall Asleep Easily?	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain or Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Do you Awaken Easily?	<input type="checkbox"/>	<input type="checkbox"/>
Dental Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Taste / Smell	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICATIONS (✓ if taking)

- | | |
|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Iron Supplements |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Pheonobarbitol |
| <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Shots |
| <input type="checkbox"/> Barbituates | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Blood Pressure Pills | <input type="checkbox"/> Thyroid Pills |
| <input type="checkbox"/> Blood Thinning Pills | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Digitalis | <input type="checkbox"/> Water Pills |
| <input type="checkbox"/> Dilantin | <input type="checkbox"/> Weight Loss Pills |
| <input type="checkbox"/> Insulin or Diabetic Pills | <input type="checkbox"/> Others (Please List): |

Reasons for Hospitalizations (none)

Previous Surgeries (none)

Medications you are ALLERGIC to (none)

Physician's Signature: _____

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 hereby 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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 Suite 208
 Farmington Hills, MI 48336
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