Cass Street Ear, Nose & Throat Associates, P.C.
Otolaryngology*Head and Neck Surgery*Allergy
1104 Cass Street, Traverse City, MI 49684 231-41-1155*Fax 231-941-1347

APPT DATE: ____________________

Patient's Information

Patient's Legal Name: ______________________________ SSN: ______________
Last First Initial

DOB: ______________ Sex: M F Marital Status: S M W D

Mailing Address: ______________________________
Street or PO Box City State Zip Code

Street Address: ______________________________
If different than above

Cell Phone #: ______________ Other Phone #: ______________ Email: ______________

Is it okay to leave a detailed message on both Phone Numbers listed above? Y N

Emergency Contact

Name: ______________ Phone #: ______________ Relationship: ______________

Spouses's Name: ______________ Spouse's DOB: ______________ Spouse SSN: ______________

Spouses's Cell Phone #: ______________ Spouses's Work/Other Phone #: ______________

Name of PHARMACY: ______________ **Pharmacy Location:** ______________

Referred By: ______________ Primary Care Physician: ______________

Insurance Information (We MUST have a copy of your Insurance Cards)

Primary Ins: ______________ Card Holder Name: ______________

Card Holder SSN: ______________ Card Holder DOB: ______________

Policy/Contract #: ______________ Group #: ______________

Secondary Ins: ______________ Card Holder Name: ______________

Card Holder SSN: ______________ Card Holder DOB: ______________

Policy/Contract #: ______________ Group #: ______________

Responsible Party Information (If Patient is a MINOR this is the LEGAL GUARDIAN Signing Contract)

Legal Guardian Name: ______________________________ DOB: ______________

Mailing Address: ______________________________
Street or PO Box City State Zip Code

Relationship to Patient: ______________ Cell Phone: ______________ Other Phone: ______________

Consent to Obtain Patient Medication History

Medication history is important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is oftentimes required to obtain authorizations for further treatment such as CT scans and surgery. **By signing this consent, I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**

Signature of Patient, Parent or Guardian: ______________________________

Authorization to Release Protected Health Information

Cass Street Ear, Nose & Throat Associates, P.C. and its employees may discuss my medical conditions/information with the following individual(s):

Name	Relationship

______________________________ ______________
Patient/Parent/Guardian Signature **Date**

Revised 1/24/2017

CASS STREET EAR, NOSE & THROAT ASSOCIATES, P.C.
HEALTH HISTORY QUESTIONNAIRE

PATIENT'S NAME:______________________ DOB:__________ AGE:_____ DATE:__________

CURRENT JOB OCCUPATION: ______________________

WHAT COMPLAINT BRINGS **YOU** HERE TODAY?: ______________________

PAST MEDICAL HISTORY –

Personal History of Cancer	YES - NO	If yes, what kind?__________	
Other Heart Disease	YES – NO	If yes, what kind?__________	
Diabetes	YES – NO	If yes, what type? __________	
Gastrointestinal Problems	YES – NO	If yes, what problem?__________	
Bleeding problems/tendencies	YES – NO	If yes, what problem?__________	
Neurological Problems	YES – NO	If yes, what problem?__________	
Eye/Vision Problems	YES – NO	If yes, what problem?__________	
Psychiatric Problems	YES – NO	If yes, what problem?__________	
Sleep Apnea/OSA	YES – NO	If yes, are you on CPAP? ______	How long have you been on CPAP? ______
Respiratory Problems	YES – NO	If yes, what problem?__________	
Rheumatology Problems	YES – NO	If yes, what problem?__________	
History of MRSA	YES – NO	If yes, where on the body? __________	
Environmental Allergies	YES – NO	If yes, what kind? __________	
High Blood Pressure/Hypertension	YES – NO	Liver Disease	YES - NO
Jaundice	YES – NO	Hepatitis:	YES – NO
Thyroid problems	YES – NO	History of Tuberculosis	YES – NO
HIV/AIDS/STD	YES – NO	GERD/Reflux	YES - NO
Depression	YES – NO	Asthma/Emphysema	YES – NO
Anxiety	YES – NO	History of kidney stones	YES – NO

Have you ever had a severe allergy reaction that required emergency treatment? If yes, describe______________________

PAST SURGICAL HISTORY

____

____

EAR/NOSE/THROAT HISTORY:

History of Ear Issues: what kind __________		Hearing Loss	YES – NO	Tinnitus/Ringing in Ears	YES – NO
Vertigo	YES – NO	Inner Ear Infections # of episodes in last year ______	YES – NO	Outer Ear Infections # of episodes in last year ______	YES – NO
History of Nasal Issues: what kind __________		Deviated Septum	YES – NO	Polyps	YES – NO
Epistaxis/Bloody Noses	YES – NO	Sinusitis	YES – NO		
History of Throat Issues: what kind __________		Vocal Cord concerns	YES - NO	Larynx or Trachea concerns	YES – NO
Thyroid nodules/masses	YES – NO	Tonsillitis	YES – NO	# of episodes in last year ______	

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO If yes, please list medication and reaction:

____

____

DO YOU TAKE ASPIRIN, BLOOD THINNERS OR IBUPROFEN YES – NO **Latex allergies/reactions** YES – NO

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE, INCLUDING OVER THE COUNTER MEDICATIONS:

Name of Medication	Strength, Dosage and Frequency	Reason for taking

SOCIAL HISTORY:

DO YOU CURRENTLY USE TOBACCO? YES – NO WHICH TYPE? (PLEASE CIRCLE) CIGARETTES CIGARS CHEW VAPOR

HOW MANY PER DAY? ________________ TOTAL YEARS YOU HAVE USED TOBACCO? ________________

ARE YOU A PREVIOUS TOBACCO USER? YES - NO IF YES, WHEN DID YOU STOP? ________________

DO YOU CONSUME ALCOHOL? YES – NO HOW MANY ALCOHOL DRINKS PER DAY ________________ PER WEEK ____________
(MEN) HOW MANY TIMES IN THE LAST YEAR HAVE YOU CONSUMED MORE THAN 5 DRINKS AT A TIME? __________
(WOMEN) HOW MANY TIMES IN THE LAST YEAR HAVE YOU CONSUMED MORE THAN 4 DRINKS AT A TIME? __________

DO YOU HAVE A HISTORY OF DRUG ABUSE OR OTHER HIV/AIDS RISKS FACTORS:________________

DO YOU HAVE A HISTORY OF NOISE EXPOSURE?________________

FAMILY HISTORY – DO ANY OF YOUR RELATIVES HAVE (HAD):

(Grandparents, Parents, Siblings and Children only)

Heart Disease	YES – NO	If YES, relation ____________	Stroke	YES – NO	If YES, relation ____________
Early Onset Hearing Loss	YES – NO	If YES, relation ____________	Asthma	YES – NO	If YES, relation ____________
High Blood Pressure	YES – NO	If YES, relation ____________	Diabetes	YES – NO	If YES, relation ____________
Environmental allergies	YES – NO	If YES, relation ____________	Cancer	YES – NO	If YES, what kind/relation ____________

HAVE YOU NOTED ANY OF THE FOLLOWING?

Onset of new headaches	YES - NO	Major hearing change	YES - NO	Hoarseness	YES - NO
Chest pain	YES - NO	Shortness of breath	YES - NO	Cough	YES – NO
Difficulties with urination	YES - NO	Heartburn or indigestion	YES - NO	Joint or muscular pain	YES - NO
Rash or skin lesion	YES - NO	Weight Loss	YES - NO	Weight Gain	YES - NO
Sleeping difficulties	YES - NO	Fatigue	YES - NO	Heat intolerance	YES - NO
Cold intolerance	YES - NO	Ear Infections If yes, # of episodes in last year: ________	YES - NO	Tonsillitis If yes, # of episodes in last year: ________	YES - NO
Recent Fever If yes, what Temp.________	YES - NO				

RADIOLOGY:
Have you had an x-ray, MRI or CAT Scan of your head or neck in the past year? YES – NO If yes, what for?________________
AUDIOLOGY:
Have you had a hearing test in the past year? YES – NO If, yes, where did you have it and when?________________

PLEASE FILL OUT THE FOLLOWING IF PATIENT IS A MINOR:

Are patient's immunizations up to date?	YES – NO	Are there brothers and /or sisters in the home?	YES – NO
Are there smokers in the home?	YES – NO	Is the patient exposed to tobacco smoke outside the home?	YES – NO
Does patient attend daycare or school?	YES – NO	Is the patient a product of a normal pregnancy and delivery?	YES – NO
Are there pets in the home?	YES – NO		

If yes, what kind?________________

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

FINANCIAL POLICY:
We are committed to providing you with the best possible care. In order to do this, we need your assistance and your understanding of our financial policy.

WE PARTICIPATE WITH THE FOLLOWING INSURANCE COMPANIES ONLY: PRIORITY HEALTH & PRIORITY HEALTH MEDICARE, BCBS TRADITIONAL & PPO, ASR, UNITED HEALTHCARE, AETNA, COFINITY, CIGNA, MEDICARE PLUS BLUE AND HUMANA GOLD.

Payment of copays and non-covered services are due at the time services are rendered. We accept Cash, Check, Money order, Visa, MasterCard, and Discover. We will submit your claim to your primary insurance carrier for you and they will reimburse you directly if we do not participate with your insurance.

We must emphasize that as Medical Care Providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered. If you have any questions about the above information, PLEASE do not hesitate to ask us, we are here to help you.

PATIENT RESPONSIBILITY:
I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any services rendered. I agree that any past due balance of mine may accrue interest at a rate up to the maximum allowable by law. I agree that the Office may add to my account balance collection expenses and fees. I agree that collection fees amounting to 50% or less, whether based on contingent fee basis or otherwise, are reasonable.

There may be a $10 processing fee to have forms such as AFLAC, disability, FMLA, work releases, etc. completed by our staff or the physicians. The may be a fee to process medical records requests in accordance with the current State of Michigan regulations.

I understand and agree that in order for this Office to service my account or to collect any amounts I may owe, I may be contacted by telephone at any telephone number associated with my account, including wireless telephone numbers. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

ASSIGNMENT OF BENEFITS: I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits of private insurance, Medicare and other government benefits either to myself or Cass Street Ear, Nose & Throat Assoc. P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also authorize the release of information necessary for my continuing medical care. The patient or guardian and the patient's spouse agree that they are jointly and severally responsible for the doctor's fees and charges incurred by the patient. It is our office policy that the person who brings a child in to the office is responsible for payment at the time the service is rendered and that any reimbursement from divorce agreements be handled by that person and not by our office.

CONSENT FOR TREATMENT: I hereby authorize Cass Street Ear, Nose, & Throat Assoc. P.C. to render medical treatment to myself or my minor child.

I have read all the above information and have completed the other side of this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the information contained on this form.

________________________________ ________________
Signature of Patient or Responsible Party Date

________________________________ ________________
Spouse's Signature Date

MEDICARE PATIENTS

____________________ ____________________ request payment of authorized Medicare benefits be made either
(Beneficiary Name) (Medicare ID Number)
to me or on my behalf to Cass Street Ear, Nose & Throat Assoc. P.C. for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This request is effective until revoked by beneficiary in writing.

________________________________ ________________
Signature of Beneficiary Date
Revised 1/24/2017

Cass Street Ear, Nose & Throat Associates P.C.
1104 Cass Street
Traverse City MI 49684
*231-941-1155 * 231-941-1347 Fax*

Acknowledgement of Offering of Notice of Privacy Practices

By Signing below I acknowledge that I was offered a copy of this office's Notice of Privacy Practices

______________________________	______________________________
(Patient Signature)	(Witness)
______________________________	______________________________
(Patient Printed Name)	(Date)

Documentation of Failure to Obtain Signed Acknowledgement

On ______________________________ (Date), ______________________________ (Employee)
presented this Acknowledgement of Offer of Notice of Practices to

______________________________ (Patient).

Above stated patient refused to provide a signature as requested.

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