Cass Street Ear, Nose & Throat Associates, P.C.
Otolaryngology*Head and Neck Surgery*Allergy
1104 Cass Street, Traverse City, MI 49684 231-941-1155*Fax 231-259-1005

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 Name: _____________________________ Spouses DOB: ________________ Spouse SSN: ____________________

Spouses Cell Phone #: ________________________ Spouses Work/Other Phone #: _______________________________

Name of PHARMACY: ________________________________Pharmacy Location: ___________________________________

Referred By: _______________________________________ Primary Care Physician: ________________________________

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

Legal Guardian Name: _____________________________________ DOB: ________________ SSN: _______________________

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 Name Relationship

Medicare Patients

I request payment of authorized Medicare benefits be made on my behalf to Cass Street Ear, Nose & Throat Associates, P.C. for any services furnished 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 Patient or Guardian: ____

Consent For Treatment

I authorize Cass Street Ear, Nose & Throat Associates, P.C. to render medical treatment to myself or my minor child.

____ __________________________________

Patient/Parent/Guardian Signature Date

☐ Acknowledgement of Offering of Notice of Privacy Practices

By checking this box, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

☐ **Documentation of Failure to Obtain Signed Acknowledgement**
Patient refuses to acknowledge Notice of Privacy Practice.

☐ Acknowledgement of Assignment of Benefits and Patient Responsibility

I understand that it is my responsibility to notify Cass Street Ear, Nose & Throat Associates, P.C. of any changes in my insurance. I understand that not updating my insurance information may result in nonpayment by my insurance carrier due to lack of authorization and/or timely filing limits.

I understand that any balance owed by me may accrue interest at a rate up to the maximum allowable by law. I understand that collection expenses and re-billing charges or late fees may be added to my account if my balance is not paid in full.

☐ Acknowledgement of Cancellation and No Show Policy

I understand the following:

No Show for Office Call: If I am a No Show for my scheduled appointment I will be charged a $30 No Show Fee.

Cancellation of Office Call: If I do not cancel or reschedule an appointment with at least 24 hours' notice I will be charged a Cancellation Fee of $30.

Allergy Testing Cancellation or No Show: If I am a No Show or I do not cancel or reschedule my Allergy Test with at least 7 days' notice I will be charged a $100 cancellation/no show fee.

Surgery/Office Procedure Cancellation or No Show: If I am a No Show or I do not cancel or reschedule my surgery with at least 14 days' notice I will be charged a $100 cancellation/no show fee.

Cancellation and No Show Fees are not covered by my insurance company and must be paid before I can reschedule my appointment.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

______________________________	______________________________
Patient/Parent/Guardian Signature	Witness Signature
______________________________	______________________________
Patient/Parent/Guardian Printed Name	Date

Revised: 6/30/2022

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

PATIENT'S NAME:___________________ DOB:__________ AGE:_____ DATE:______________

Current Occupation: ____________________ What complaint brings you here today: ____________________

PAST MEDICAL HISTORY:

Condition	Answer	Details
Arthritis/Rheumatoid Problems	YES – NO	If yes, what problem?________________
Asthma/Emphysema/COPD	YES – NO	If yes, what problem?________________
Eye/Vision Problems	YES – NO	If yes, what problem?________________
Hepatitis/Liver Disease	YES – NO	If yes, what type? ________________
Heart Disease	YES – NO	If yes, what kind?________________
Anxiety	YES – NO	
Depression	YES – NO	
Diabetes	YES – NO	If yes, what type? ________________
High Blood Pressure/Hypertension	YES – NO	
Human Immunodeficiency Virus (HIV)	YES – NO	
High Cholesterol/Hyperlipidemia	YES – NO	
Bleeding Disorder/Hemophilia	YES – NO	If yes, what problem?________________
Kidney Stones	YES – NO	
Neurological Problems	YES – NO	If yes, what problem?________________
Gastrointestinal Problems	YES – NO	If yes, what problem?________________
Psychiatric/Mental Problems	YES – NO	If yes, what problem?________________
Personal History of Cancer	YES - NO	If yes, what kind?________________
History of MRSA	YES – NO	If yes, where on the body? ________________
History of Tuberculosis	YES – NO	
Sexually Transmitted Disease	YES –NO	If yes, what kind? ________________

PAST SURGICAL HISTORY: ____

____

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?________________

EAR/NOSE/THROAT PAST MEDICAL HISTORY

Outer Ear Infections — Right – Left – Both – None
# of episodes in last year ________________

Inner Ear Infections — Right – Left – Both - None
# of episodes in last year ________________

Condition	Answer
Environmental Allergies	YES – NO
Deviated Septum	YES - NO
Epistaxis/Bloody Noses	YES – NO
History of Noise Exposure	YES – NO
GERD/Reflux	YES – NO
Headache	YES – NO
Hearing Loss	Right – Left – Both – None
Hoarseness	YES – NO
Neck Mass	YES – NO
Nasal Polyps	YES - NO
Sinusitis	YES - NO

Sleep Apnea/OSA YES – NO If yes, are you on CPAP? ____________
How long have you been on CPAP? ____________

Condition	Answer
Thyroid Nodules/Masses	YES - NO
Tinnitus/Ringing in Ears	Right – Left – Both - None
Tonsillitis/Strep Throat	Yes – No # of episodes per year _____
Vertigo	Right – Left – Both - None
Vocal Cord Paralysis	YES - NO

PLEASE FILL OUT THE FOLLOWING IF PATIENT IS A MINOR:

Question	Answer	Question	Answer
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 no, what kind?________________	

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

Name of Medication	Dosage	Frequency	Reason for taking

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

____

____

Do you have any food allergies? YES NO If yes, please list food and reaction: ___________________________________

____

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

SOCIAL HISTORY:

Do you currently use tobacco? YES – NO Which type? cigarettes cigars chew vapor

How many packs per day? _____________ Total years you have used tobacco? ____________________

Are you a previous tobacco user? Yes - NO If yes, when did you stop? ____

Do you have a history of Past or Current drug use including medical marijuana? YES – NO _________________________

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? _______________

PATIENTS 64 AND OLDER:

Have you ever received a pneumonia vaccination? Yes No
Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes No
Do you have a living will? Yes No
Which statement best reflects your wishes on advanced care recommendations:
□ Do Not Intubate □ Do Not Resuscitate □ Full Cardiopulmonary Resuscitation

FAMILY HISTORY: (Grandparents, Parents, Siblings and Children only) DO ANY OF YOUR RELATIVES HAVE (HAD):

Malignant Hyperthermia YES – NO If YES, relation _________________________ Heart Disease YES – NO If YES, relation __________________________

Early Onset Hearing Loss YES – NO If YES, relation _________________________ Stroke YES – NO If YES, relation _______________________________

High Blood Pressure YES – NO If YES, relation ________________________ Diabetes YES – NO If YES, relation ______________________________

Environmental allergies/Asthma YES – NO If YES, relation ___________________ Cancer YES – NO If YES, what kind/relation ____________________

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

Onset of new headaches	YES - NO	Hearing Loss	YES - NO	Cough	YES – NO
Chest pain	YES - NO	Shortness of breath	YES - NO	Joint or muscular pain	YES - NO
Rash or skin lesion	YES - NO	Heartburn or indigestion	YES - NO	Ear Infection	YES - NO
Sleeping difficulties	YES - NO	Weight Loss	YES - NO	Ear Pain	YES - NO
Cold intolerance	YES - NO	Weight Gain	YES - NO	Vertigo	YES - NO
Heat intolerance	YES - NO	Fatigue	YES - NO	Tinnitus	YES - NO
Recent Fever YES – NO	If yes, Temp._________	Hoarseness	YES - NO	Nasal Obstruction	YES - NO

Do you take Aspirin, Blood Thinners or Ibuprofen on a daily basis? YES – NO **Latex allergies/reactions** YES – NO

Have you received the COVID-19 Vaccination? YES – NO If Yes, Have you received the COVID-19 Booster? YES – NO