ENT FACULTY PRACTICE

Please print clearly

Patient Age: _____ **If Patient is a minor please indicate:**

Mother's Name:_____ **Father's Name:_____**

Mother's Occupation:_____ **Father's Occupation: _____**

Patient Name: _____

Address: _____

City:_____State: _____Zip Code: _____

Home #:_____ Work#: _____ Cell#:_____

Patient DOB:_____ Patient Sex: _____

SS#: _____ Patient Marital Status: ___Single __Married __Other

Language: (please circle one) Chinese English French German Italian
Japanese Portuguese Russian Spanish

Race: (please circle one) American Indian/Alaska Native Asian Black/African American
Native Hawaiian/Other Pacific Islander Other Race White

Ethnicity:(please circle one) Hispanic or Latino Not Hispanic or Latino Unknown

Email Address:_____

Emergency Contact:_____ Phone #:_____

Employer Name: _____

Address: _____

Primary Dr: _____ **Referring Dr: _____**

Address:_____ **Address:_____**

Phone #:_____ **Phone #:_____**

Fax#:_____ **Fax#:_____**

Pharmacy Name_____Phone:_____

Address_____

Prescription Coverage_____ ID#_____ Phone# :_____

*****Patient Signature:_____ Date:_____**

ENT FACULTY PRACTICE

Please print clearly

Name:_____ **DOB:**_____

Insurance Information:

Primary Ins:_____ **Policy #:**_____ **Group #:**_____

Address:_____

Phone # :_____

Policy Holder Name:_____

Policy Holder DOB_____**Policy Holder SS#:**_____

Policy Holder Relation to Patient: _____

Secondary Ins:_____ **Policy #:**_____ **Group #:**_____

Address:_____

Phone # :_____

Policy Holder Name:_____ **Relation to Patient:** _____

Policy Holder DOB: _____**Policy Holder SS#:**_____

*****Patient Signature:**_____ **Date:**_____

ENT FACULTY PRACTICE - PATIENT QUESTIONNAIRE

Dear Patient,

Please answer the following medical questions. ***Please be reassured that patient privacy is a top priority!***

Date:_____

Name: _____**D.O.B.**_____ **Age:** _____

Occupation:_____

Reason for Visit? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Length of time you had this problem:_____

TABLE 1

Reflux Symptom Index (RSI)

Within the last MONTH how did the following problems affect you?	0 = No Problem 5 = Severe Problem					
1. Hoarseness or a problem with your voice	0	1	2	3	4	5
2. Clearing your throat	0	1	2	3	4	5
3. Excess throat mucous or postnasal drip	0	1	2	3	4	5
4. Difficulty swallowing food, liquids, or pills	0	1	2	3	4	5
5. Coughing after you ate or after lying down	0	1	2	3	4	5
6. Breathing difficulties or choking episodes	0	1	2	3	4	5
7. Troublesome or annoying cough	0	1	2	3	4	5
8. Sensations of something sticking in your throat or a lump in your throat	0	1	2	3	4	5
9. Heartburn, chest pain, indigestion, or stomach acid coming up	0	1	2	3	4	5

Voice Handicap Index (VHI-10), Henry Ford Hospital

Please circle the response that indicated how frequently you have these experiences:
0 = never 1 = almost never 2 = sometimes 3 = almost always 4 = always

My voice makes it difficult for people to hear me	0	1	2	3	4
People have difficulty understanding me in a noisy room.	0	1	2	3	4
My voice difficulties restrict my personal and social life.	0	1	2	3	4
I feel left out of conversations because of my voice.	0	1	2	3	4
My voice problem causes me to lose income.	0	1	2	3	4
I feel as though I have to strain to produce voice.	0	1	2	3	4
The clarity of my voice is unpredictable.	0	1	2	3	4
My voice problem upsets me.	0	1	2	3	4
My voice makes me feel handicapped.	0	1	2	3	4
People ask “What’s wrong with your voice?”	0	1	2	3	4

Swallowing Follow up assessment

Name: Date:

Eating Assessment Tool - 10

Please circle to the response that indicates how frequently you have these experiences.

0 = never 1 = almost never 2 = sometimes 3 = almost always 4 = always

My swallowing problem has caused me to lose weight..	0	1	2	3	4
My swallowing problem interferes with my ability to go out to eat	0	1	2	3	4
Swallowing liquids takes extra effort. .	0	1	2	3	4
Swallowing solids takes extra effort.	0	1	2	3	4
Swallowing pills takes extra effort.	0	1	2	3	4
Swallowing is painful .	0	1	2	3	4
The pleasure of eating is affected by my swallowing.	0	1	2	3	4
When I swallow, food sticks in my throat	0	1	2	3	4
I cough when I eat .	0	1	2	3	4
Swallowing is stressful .	0	1	2	3	4

Glottal Function Index

Within the last MONTH, 0 = No problem, 5 = Severe problem

How did the following problems affect you ?

1.	Speaking took extra effort	0	1	2	3	4	5
2.	Throat discomfort or pain after using your voice	0	1	2	3	4	5
3.	Vocal fatigue (voice weakened as you talked)	0	1	2	3	4	5
4.	Voice cracks or sounds different	0	1	2	3	4	5

Cough Severity Index

Please fill out this questionnaire *if you experience cough* as a symptom.

Please circle to the response that indicates how frequently you have these experiences.

0 = never 1 = almost never 2 = sometimes 3 = almost always 4 = always

1. My cough is worse when I lie down.	0 1 2 3 4
2. My coughing problem causes me to restrict my personal and social life.	0 1 2 3 4
3. I tend to avoid places because of my cough problem.	0 1 2 3 4
4. I feel embarrassed because of my coughing problem.	0 1 2 3 4
5. People ask, ‘‘What’s wrong?’’ because I cough a lot.	0 1 2 3 4
6. I run out of air when I cough.	0 1 2 3 4
7. My coughing problem affects my voice.	0 1 2 3 4
8. My coughing problem limits my physical activity.	0 1 2 3 4
9. My coughing problem upsets me.	0 1 2 3 4
10. People ask me if I am sick because I cough a lot.	0 1 2 3 4

Name:_____**D.O.B**_____

Have you ever had any of these medical problems in the **PAST** (please check all that apply)?

☐ **Check Here, If No Past Medical Problems.**

CARDIOVASCULAR: ☐ **NONE**	☐ Coronary Artery Disease ☐ Heart Surgery	☐ Elevated Cholesterol ☐ High Blood Pressure	☐ Heart Attack
EYE/EAR/NOSE/THROAT: ☐ **NONE**	☐ Cataracts ☐ Hearing Loss ☐ Sinus Problems	☐ Glaucoma ☐ Nasal Polyps ☐ Tinnitus	☐ Chronic Ear Infections ☐ Recurrent Acute Tonsillitis ☐ Vertigo
GASTROINTESTINAL: ☐ **NONE**	☐ Hepatitis ☐ Liver Disease	☐ Hernia (Hiatal)	☐ GERD (Gastroesophageal Reflux)
PULMONARY: ☐ **NONE**	☐ Asthma ☐ Sleep Apnea	☐ COPD	☐ Tuberculosis
GENITOURINARY: ☐ **NONE**	☐ Prostate Enlargement ☐ Hernia	☐ Kidney Stones	☐ Acute Renal Failure
HEMATOLOGIC: ☐ **NONE**	☐ Bleeding Disorder	☐ Anemia	
INFECTIOUS DISEASE: ☐ **NONE**	☐ HIV/AIDS ☐ Bronchitis	☐ Mononucleosis ☐ Pneumonia	☐ STD Type:_____
METOBOLIC/ENDOCRINE: ☐ **NONE**	☐ Diabetes Type: _____	☐ Thyroid Deficiency (Hypothyroidism)	☐ Thyroid Excess (Hyperthyroidism)
CANCER: ☐ **YES** ☐ **NO**	Enter Type:_____	Enter Type:_____	Enter Type: _____
NEUROLOGIC: ☐ **NONE**	☐ Migraines ☐ Seizures	☐ Other Disorder (Parkinson's, Alzheimers, ALS, MS): Enter Type: _____	☐ Stroke ☐ Neuropathy
OBSTETRIC: ☐ **NONE**	☐ Complications During Pregnancy	☐ Complications During Delivery	☐ Preterm Birth
PSYCHIATRIC: ☐ **NONE**	☐ Adjustment Disorder - Anxiety	☐ Major Depressive Disorder	
AUTOIMMUNE DISEASE: ☐ **NONE**	Type_____		

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE: ☐ **NONE**

For any indicated Medical problems was surgery performed (fill in as much information as possible)? ☐ **NONE**

Date or Age:_____ **Facility:**_____ **Treatment/Surgery:**_____**Physician:**_____

Date or Age:_____ **Facility:**_____ **Treatment/Surgery:**_____**Physician:**_____

Date or Age:_____ **Facility:**_____ **Treatment/Surgery:**_____**Physician:**_____

Name: _____ D.O.B _____

Medications:
List medications and vitamins that you take on a regular basis. ☐ **NONE**
(Please include Supplements, Homeopathic, Herbal and Over The Counter Medicines)

Medication:_____ Dosage(if known):____ Medication:_____ Dosage(if known):____
Medication:_____ Dosage(if known):____ Medication:_____ Dosage(if known):____
Medication:_____ Dosage(if known):____ Medication:_____ Dosage(if known):____

Allergies:

☐ **Check Here, If No Known Food Allergies.**
☐ **Check Here, If No Known Environmental Allergies.**

Do you have any of the following Food or Environmental Allergies (please check all that apply)?

☐Adhesive Tape	☐Beans	☐Dairy	☐Dogs ☐Cats
☐Eggs	☐Feathers	☐Seafood (fish)	☐Latex
☐Peanuts ☐Dustmites	☐Pollen ☐Trees/Grass	☐Rag Weed ☐Mold	☐Other: _____

☐ **Check Here, If No Known Drug Allergies.**

Do you have any of the following Drug Allergies (please check all that apply)?

☐Ace Inhibitors	☐Aspirin	☐Codeine	☐Macrolides (Mycin Drugs)
☐Sulfas	☐IVP Dye, Iodine Containing	☐NSAIDS (Motrin/Advil/Ibuprofen)	☐Penicillin's
☐Tetracyclines	☐ Tylenol	☐Other: _____	☐Other: _____

Have you ever had any problems or reactions to Anesthesia? ☐ NO ☐ YES **If yes, please explain:**_____
_____

Social History:

Do you, or have you ever smoked? ☐ **N/A**

☐ I've Never Smoked	☐ Currently Smoke Cigars
☐ A Former Smoker - ___ Pack(s)/Day Age Started:_____	Age Stopped:_____ Year Quit:_____
☐ Currently Smoke Cigarettes - ___ Pack(s)/Day	☐ Currently Smoke a Pipe

Do you drink alcohol (please check)? ☐ **N/A**

☐ Rarely or Never	☐ Drink Daily
☐ Occasionally (Social)	☐ Former Alcohol Intake, None For ____ Years.

Do you use recreational drugs? ☐ **Yes** ☐ **No** ☐ **N/A**

☐ Amphetamines Dates of use _____ to _____	☐ Intravenous Drugs Type: _____ Dates of use _____to _____
☐ Barbituates Dates of use _____ to _____	☐ Marijuana Dates of use _____ to _____
☐ Cocaine/Crack Dates of use _____ to _____	☐ MDMA (Ecstasy) Dates of use _____ to _____

Are you presently or have you ever been exposed to a second hand smoke hazard?

☐ No	☐ Yes – (circle one, or both) Presently Past

Do you consume caffeine?

☐ Yes (Circle): Coffee Tea Other Beverage(s)	☐ No

What is Your Water (H_2O) Intake? If so, how much…

_____ (Circle One): Glasses/Ounces Per Day/Unknown

Name: _____ D.O.B. _____

Family History (Please Place Check Marks Below):

If history unknown check here ☐

RELATION: **FAMILY HISTORY OF:**	**CHILD**	**PARENT**	**SIBLING**	**GRANDPARENT**	**OTHER RELATIVE**
ADD-Attention Deficit	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Alzheimer Disease	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐	☐
Migraines (Common)	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐

Please enter if anyone in your family (child, parent, grandparent, sibling, other relative) has had the Same or Similar ENT (ear, nose, throat) related problem as the reason for your visit: ☐ NONE

Problem: _____ Family Member(s):_____

Problem: _____ Family Member(s):_____

Problem: _____ Family Member(s):_____

Name: _____ D.O.B. _____

"Review of Systems":

Put a check next to the medical issues you CURRENTLY have, fill in "Other", or "No Problems":

Constitutional: ☐ **No Problems** ☐ Fever ☐ Chills ☐ Night Sweats ☐ Dizziness
Other:_____

Cardiovascular: ☐ **No Problems** ☐ Chest Pain ☐ Swelling of Extremities ☐ High Blood Pressure
Other:_____

Endocrine: ☐ **No Problems** ☐ Thyroid Problem ☐ Diabetes
Other:_____

Eyes: ☐ **No Problems** ☐ Blurry Vision ☐Double Vision ☐ Itchiness ☐ Blindness ☐ Photophobia
Other:_____

Gastrointestinal: ☐ **No Problems** ☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Liver Problem ☐ Diarrhea
Other:_____

Respiratory: ☐ **No Problems** ☐ Asthma ☐ Pneumonia ☐ Cough ☐ Sputum ☐ Wheezing ☐ Tuberculosis
Other:_____

Genitourinary: ☐ **No Problems** ☐ Bleeding ☐ Burning ☐ Kidney Stones ☐ Prostate Problem
Other:_____

Hematologic: ☐ **No Problems** ☐ Easy Bruising ☐ Anemia ☐ Clotting Problem
Other:_____

Immunologic: ☐ **No Problems** ☐ HIV Positive ☐ AIDS
Other:_____

Lymphatic: ☐ **No Problems** ☐ Nodes ☐ Lumps
Other:_____

Musculoskeletal: ☐ **No Problems** ☐ Pain ☐ Swelling ☐ Weakness ☐ Stiffness ☐ Arthritis
Other:_____

Neurological: ☐ **No Problems** ☐ Numbness ☐ Memory Problems ☐ Vertigo
Other:_____

Ob/Gyn (females only): ☐ **No Problems** ☐ Pregnant ☐ Irregular Periods ☐ Discharge
Other:_____

Psychiatric: ☐ **No Problems** ☐ Depression ☐ Anxiety ☐ Hallucinations ☐ Suicidal Tendency ☐ Drug Addiction
Other:_____

Skin: ☐ **No Problems** ☐ Rash ☐ Lesion ☐ Pain
Other:_____

ENT FACULTY PRACTICE, LLP

OFFICE POLICY

PATIENT FINANCIAL RESPONSIBILITY

I agree to assume all financial responsibility for the medical care, treatment and other related services provided to myself and/ or to _____
by ENT Faculty Practice, LLP. (Name of Patient)

If my co-payment is not paid at the time of my visit I am responsible for an administrative charge of $20.00 in addition to my co-pay.

If payment is not made today, I understand that any balance owed must be paid full within 30 days from the date of my bill; If payment is made later than 30 days from the date of my bill, I understand that I am responsible for interest charges, which will accrue at a rate of 1.5% per month.

I am responsible for the collection fees, attorney's fees and any other costs associated with collecting this bill or any of my bills in the future. If I fail to remit any fees due to ENT Faculty Practice, LLP. If a check I issue to ENT Faculty Practice, LLP is returned unpaid by my bank for any reason, I agree to be responsible for a returned check charge of $25.00.

I am aware that whether ENT Faculty Practice, LLP does or does not participate with my insurance, any charges not covered are my responsibility. Once insurance payments are made, any balance stating "patient due" on the Explanation of Benefits is also my responsibility. This may include multiple co-pays per visit, deductibles and co-insurance. If the insurance company denies the claim, it is my responsibility to pay ENT Faculty Practice, LLP. As a courtesy, ENT Faculty Practice, LLP will bill the insurance company a routine medical claims form for services provided out of network.

_____ _____
Signature of Responsible Party Print Name of Responsible Party

_____ _____
Print Patients Name Date

ENT FACULTY PRACTICE, LLP

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize and direct my insurance carrier to make payment directly to ENT Faculty Practice, LLP and hereby assign to said office and any and all rights, title and interest I have in insurance proceeds or benefits payable to me or on my behalf for services rendered to me by said medical office.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE NAMED MEDICAL OFFICE FOR ALL CHARGES, INCLUDING THOSE NOT PAID BY INSURERS OR THIRD PARTIES, INCURRED BY ME OR ON MY BEHALF.

I hereby authorize and direct the above named medical office and my attending physician to release such medical information from my medical records as is necessary to complete forms for payment by insurance and other payers.

_____ _____

Date Time Signature of patient/responsible person

_____

Witness

IF PERSONS OTHER THAN THE PATIENT SIGNS, INDICATE RELATIONSHIP TO THE PATIENT AND REASON FOR LACK OF PATIENTS SIGNATURE.

ENT FACULTY PRACTICE, LLP
PATIENT RELEASE OF MEDICAL INFORMATION

On November 20, 2000, President William Clinton enacted “Patient Privacy Regulation”. As these regulations cover most aspects of how physicians relate to each other, hospitals, insurers, and employers, the faculty physicians and surgeons at ENT Faculty Practice, LLP want to protect your rights. We need your written permission to indicate your wishes in each of the following areas. Please circle yes or no to indicate your choice.

The physicians and surgeons, and/or their staff, of ENT Faculty Practice, LLP may release verbally or in writing medical Information to a pharmacy as required for prescribing medications or obtaining authorization by your insurer.

YES NO

The physicians and surgeons, and/or their staff , of ENT Faculty Practice, LLP may release verbally or in writing medical Information to the insurer as part of scheduling surgery, performing laboratory tests, or other tests, admitting you to the hospital, or providing medical care.

YES NO

The physicians and surgeon, and/or their staff, of ENT Faculty Practice, LLP may release verbally or in writing medical Information to my employer. This release includes: 1) releases to return to work, 2) insurance forms related to medical coverage or worker’s compensation, 3) letters indicating medical reasons for doctor’s appointments or other reasons leading to missed days of work.

YES NO

The physicians and surgeons, and/or their staff, of ENT Faculty Practice, LLP may discuss my medical condition with other physicians involved in my medical care.

_____ _____

Your name Date

Other Instructions:

_____

_____

_____

PATIENT HIPPA AWARENESS

With my permission, ENT Faculty Practice, LLP may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ENT Faculty Practice, LLP Notice of Privacy Practices for more complete description of such uses and disclosures.

It is my responsibility to review the Notice of Privacy Practices prior to signing this consent. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of ENT Faculty Practice, LLP, may call my home or other designated locations and leave a message on my voice mail or in person in reference to any item that assists the practice in carrying out TPO , such as appointments, reminder cards, and patient statements. I have the right to request the ENT Faculty Practice, LLP restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does it is bound to this agreement.

By signing this, I am allowing ENT Faculty Practice, LLP to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN

PRINT NAME OF PATIENT PARENT OR LEGAL GUARDIAN

PATIENT'S NAME: _____

DATE: _____

ENT Faculty Practice, LLP

OFFICE REFERRAL POLICY

PLEASE READ AND SIGN

Please initial box 1 or 2 below:

1. □ I am aware that the terms of my insurance contract requires me to obtain a referral form from my participating primary care physician before receiving the services I seek at our practice.
***Please note that a referral cannot be backdated.**

2. □ To my knowledge my insurance company does not require a referral for services provided by a specialist. If my insurance company denies my claim stating that a referral is necessary, I am aware that I will be financially responsible for the provider's full charges for services provided to me or my dependant.
*** Please note that a referral cannot be backdated.**

If you have any questions about the referral process under your benefit contract or are not sure whether a referral is required before receiving the services you seek today, please contact your insurance customer service at the phone number listed on the back of most insurance cards.

By signing below I am acknowledging my consent to pay directly to the provider all charges arising from my or my dependent's office visit today.

Print name of patient and legal guardian (if applicable)

_____

(Patient/Legal Guardian)

Contract Holder's Name _____

Contract Holder's ID No._____

Accept and agreed _____

Witness _____