Patient Demographic Form

Today's Date: _____/_____/_____ Age: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Date Of Birth: _____/_____/_____ Social Security #: _____ Gender: ☐ Male / ☐ Female

Patient Name: _____ Nickname: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Pharmacy: _____ Pharmacy Phone: _____
Name & Address or Location

Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Medical Insurance: _____
Name & Address

Policy Holder: _____ Policy Holder Date Of Birth: _____/_____/_____

Policy Number: _____ Group Number: _____

Secondary Medical Insurance: _____
Name & Address

Policy Holder: _____ Policy Holder Date Of Birth: _____/_____/_____

Policy Number: _____ Group Number: _____

HOW DID YOU HEAR ABOUT US?

☐ PHYSICIAN (Name: _____) ☐ FAMILY/FRIEND (Name: _____)

☐ INSURANCE (Name: _____) ☐ MAILER (Audiology)

☐ NEWSPAPER ☐ GOOGLE ☐ WEBSITE ☐ MAGAZINE (Suburban Living)

☐ HOSPITAL (Name: _____) ☐ FORMER PATIENT

In consideration of these medical services rendered by Great Lakes Ear Nose & Throat Specialists and the treating physician(s), I hereby assign any medical reimbursement to Great Lakes Ear Nose & Throat Specialists and the treating physician(s). ***I authorize the release of any medical information in my medical records necessary to process any insurance claims.***

I understand that any fees for services rendered are my responsibility. If I am a participant in an insurance plan that requires a referral from my primary care physician and I do not have that written referral or referral number, all fees for services rendered will be my responsibility. If my health insurance policy is not in force at the time of the service, I accept full responsibility for all fees. ***I authorize the release of any part of my medical record to other physicians and facilities that are participating in my care.***

_____ _____
Patient/Responsible Party Signature Date

Patient Health History

Patient Name:_____ **DOB: ___/___/_____ Today's Date ___/___/_____**

PATIENT'S PAST MEDICAL HISTORY (Check all items that apply)

Allergic Rhinitis	□
Allergy Testing	□
Alcoholism	□
Anemia	□
Asthma	□
Birth Defects	□
Bleeding Disorder	□
Cancer: (_____)	□
COPD (Emphysema)	□
Diabetes: □ T1 □ T2	□
Epilepsy	□
Glaucoma	□
Headaches	□
Heartburn (GE reflux)	□
Heart Failure	□
High Blood Pressure	□
HIV	□
Kidney Disease/Failure	□
Mental Illness	□
MRSA Infection	□
Seizures	□
Sinusitis	□
Sleep Apnea	□
Stroke	□
Thyroid Disease	□
Venereal Disease	□

PAST SURGICAL HISTORY (Check all items that apply)

Adenoidectomy	□
Blood Transfusion	□
Cosmetic	□
Ear Tubes	□
Facial or Nasal Fracture	□
Heart Surgery	□
Mastoid Ear Surgery	□
Nasal Surgery	□
Neck Surgery	□
Pacemaker	□
Septoplasty	□
Sinus Surgery	□
Stapes Ear Surgery	□
Thyroid Surgery	□
Tonsillectomy	□
Tympanoplasty	□
Vocal Cord	□
Other (_____)	□
Other (_____)	□
Other (_____)	□
Other (_____)	□

FAMILY MEDICAL HISTORY (Check all items that apply)

Allergic Rhinitis	□
Allergy Testing	□
Alcoholism	□
Anemia	□
Asthma	□
Birth Defects	□
Bleeding Disorder	□
Cancer: (_____)	□
COPD (Emphysema)	□
Diabetes: □ T1 □ T2	□
Epilepsy	□
Glaucoma	□
Headaches	□
Heartburn (GE reflux)	□
Heart Failure	□
High Blood Pressure	□
HIV	□
Kidney Disease/Failure	□
Mental Illness	□
MRSA Infection	□
Seizures	□
Sinusitis	□
Sleep Apnea	□
Stroke	□
Thyroid Disease	□
Venereal Disease	□

MEDICATION HISTORY

(Please list all medications that you are taking- prescription, over-the-counter, and herbal medications)

Medication	Medication	Medication	Medication

Are you allergic to any medications? □ Yes □ No

If yes, please list: _____

SOCIAL HISTORY: (Check all items that apply)

Do you drink alcoholic beverages? □ Yes □ No If yes, □Daily □Occasional □Never □Former

Do you smoke cigarettes? □ Yes □ No If yes, □Daily □Occasional □Never □Former

Do you use recreational drugs? □ Yes □ No If yes, □Daily □Occasional □Never □Former

Patient Health History

Review of Systems: (Check all that apply)

General
□ Fever
□ Unintentional weight change
□ Night Sweats
Eyes
□ Change in vision
□ Eye pain
Ears
□ Hearing loss
□ Slowly progressive hearing loss
□ Ear pain/pressure
□ Ear wax
□ Tinnitus (ringing or noises in the ears)
□ Ear drainage
□ Exposure to loud noise
□ Spinning/dizziness
Nose/Sinus
□ Headache
□ Facial pain/ pressure
□ Nasal drainage
□ Nasal congestion
□ Frequent sinus infections
□ Altered sense of smell
□ Nose bleeds
□ Post nasal drip
Mouth
□ Dental problems
□ Burning tongue
□ Growth or sores
□ Altered sense of taste
□ Teeth grinding
□ Jaw pain
Throat
□ Snoring
□ Hoarseness
□ Frequent throat clearing
□ Recurrent sore throat
□ Difficulty swallowing

Neck
□ Neck lumps or pain
□ Swollen glands
Cardiovascular
□ Chest pain
□ Irregular heart beat
Respiratory
□ Asthma
□ Wheezes
□ Cough
□ Dry cough
□ Shortness of breath
Hematologic (Blood) / Lymphatic
□ Bleeding problems
□ Bruises easily
Gastrointestinal / (GI)
□ Heartburn
□ Nausea or vomiting
□ Abdominal pain
□ Increase mucus in the throat
Neurological
□ Seizures
□ Depression
Endocrine (Hormones)
□ intolerance to heat/cold
□ Change in appetite
□ Increased fatigue
□ Change in hair
Allergy/Immunologic
□ Food intolerances
□ Frequent sneezing
□ Hives
□ Nasal drainage
□ Nasal itching
□ Frequent colds
□ Itchy eyes
Integumentary (Skin)
□ Rash
□ Skin changes

Patient Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing Great Lakes Ear Nose & Throat Specialists! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

Payment is Due at the Time of Service

- We accept cash, checks, debit and CareCredit®.
- All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service.
- Insurance-required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule.
- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of $50 on the date of service.
- Patient-responsible balances are due when you check in for your appointment.
- In the event you need surgery, we will provide you an estimate of your insurance required deductible and co-insurance amounts.

Proof of Insurance

- Your insurance card(s) and a valid photo ID are required at the time of the appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Self-Pay Accounts

- Self-pay patients, please be prepared to pay a minimum of $100 on the date of service. There may be additional fees for in-office procedures, labs or services.

Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance-required referral, the insurance company may deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, co-insurance, deductibles and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service, no matter if the account is self-pay, participating insurance or nonparticipating insurance. The Practice does not honor divorce specifics (e.g., percentage of financial responsibility).

No-Show/Cancellation Policy

- Please be advised that cancellations made less than 24 hours before a scheduled appointment will be subject to a $25 cancellation fee.
- Not showing up for your scheduled appointment will also result in a $25 no-show fee. If you are scheduled for an audiology and ENT appointment on the same day, this is considered as two appointments, and therefore, the charge will be $50 for said no-show/same-day cancellation fees.

- The cancellation/no-show fee is **required** to be paid before another appointment can be made.
- If you are a no-show or cancel for three appointments, Great Lakes Ear Nose & Throat will have the option of discharging you as a patient from the Practice.

____ I have read, understand and agree to the above No-Show/Cancellation Policy.

Billing, Payments and Refunds

- If we must send you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financially responsible party.

____ We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action or terminate you as a patient of this Practice. I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

____ I authorize my insurance benefits to be paid directly to **Great Lakes Ear Nose & Throat Specialists.**

____ I authorize **Great Lakes Ear Nose & Throat Specialists**, through its appropriate personnel, to perform or have performed upon me or the above-named patient appropriate assessment and treatment procedures.

____ I authorize **Great Lakes Ear Nose & Throat Specialists** to release to appropriate agencies any information acquired in the course of my or the above-named patient's examination and treatment.

Acknowledgment of Great Lakes Ear Nose & Throat Specialists Notice of Financial Policy

I hereby acknowledge that I have reviewed, received or have been given the opportunity to receive a copy of **Great Lakes Ear Nose & Throat Specialists'** Notice of Financial Policy.

X Patient/Guarantor Signature: _____ Date: _____

Great Lakes
EAR NOSE & THROAT SPECIALISTS

Acknowledgment Of Receipt Of Notice

I acknowledge that I received the NOTICE OF PRIVACY PRACTICES for Great Lakes Ear Nose & Throat Specialists.

Name of Patient: _____ DOB: _____ Today's Date: _____

Personal Representative, Parent or Guardian Information (if applicable):

Name: _____

Relationship to Patient (or other authority): _____

I hereby authorize you to discuss or release any of my information to the following:
(such as spouse, parent or family member)

Name	**Relationship**
_____	_____
_____	_____
_____	_____

Please sign below to indicate that you have read this acknowledgment and have had an opportunity to ask questions.

Signature of Patient or Personal Representative: _____ Date: _____