Michigan Ear Institute, P.L.L.C.

Office Use_____

PATIENT INFORMATION (PLEASE PRINT)

Full Legal Name

_____
First Middle Initial Last

Address _____

_____

City_____State_____ Zip _____

_____

Home Phone # (___) _____

Cell Phone # (___) _____

Emergency # (___) _____

E- Mail _____

Occupation: _____

Sex ☐ M ☐ F

Marital Status ☐ S ☐ M

☐ W ☐ D

Birthdate _____

Soc. Sec # _____

Height _____ Weight _____

Language: ☐ English

☐ Other:_____

Race: ☐ Caucasian

☐ African American

☐ Middle Eastern

☐ Asian

☐ Hispanic

☐ Other

Ethnicity: ☐ Hispanic

☐ Non Hispanic

NAME:_____ **Date of Birth:**_____/_____/_____

INSURANCE INFORMATION ***(Please bring all insurance cards to your appointment and a PICTURE ID)***

IS THIS AN ACCIDENT OR WORK RELATED INJURY? ☐ **Yes** ☐ **No**

**Primary Insurance Company:*_____ Is this an HMO? ☐ Yes ☐ No

Subscriber's Name (if different than patient) _____

Relationship to patient_____ Subscriber date of birth: _____

Subscriber SS#:_____

Subscriber Employer:_____ Employer Phone #: _____

**Secondary Insurance Company:*_____ Is this an HMO? ☐ Yes ☐ No

Subscriber Name_____

Relationship to patient_____ Subscriber date of birth: _____

Subscriber SS#:_____

Subscriber Employer:_____ Employer Phone #:_____

*Tertiary Insurance Company:*_____ Is this an HMO? ☐ Yes ☐ No

Subscriber Name_____

Relationship to patient_____ Subscriber date of birth: _____

Subscriber SS#:_____

Subscriber Employer:_____ Employer Phone #: _____

Referring Physician Name: (Please bring information) Phone #: _____

_____

_____ Fax #:_____

_____

Primary Care Physician - Family Doctor ***(MUST HAVE FOR HMO INSURANCE)***

_____

_____ Fax #:_____

_____

Additional Doctors that need to be updated on your visit, please provide your information.

NAME:_____ **Date of Birth:**_____/_____/_____

Chief Complaint: What symptoms are you having that brings you to visit this doctor.

_____

_____

Describe your present problem:

EARS	**Right**	**Left**	**Duration**
Hearing loss	_____	_____	_____
Fluctuating Hearing	_____	_____	_____
Ear Fullness	_____	_____	_____
Ringing/Tinnitus/ Buzzing	_____	_____	_____

Have you ever worn a Hearing Aid? ☐ Yes ☐ No

Have you had a problem with ear infections? ☐ Yes ☐ No

Have you had significant noise exposure (example working with loud machines or guns such as in military exposure or hunting)? ☐ Yes ☐ No

Have you had surgery on your ears? ☐ Yes ☐ No

If Yes , what type: _____

Do you have dizziness? ☐ Yes ☐ No

When did it begin?_____

How long does it last?_____

How often does it happen?_____

Is it ☐ Mild ☐ Moderate ☐ Severe

Does your dizziness affect your ability to work? ☐ Yes ☐ No

Does your dizziness affect your ability to drive? ☐ Yes ☐ No

Describe your dizziness: Check appropriate boxes

Spinning/Vertigo ☐ Lightheadness ☐ Off Balance ☐ Positional

Is it associated with ☐ Headache or ☐ Nausea

Have you ever been diagnosed with Migraine headaches? ☐ Yes ☐ No

Do you have problems with: (Check box if appropriate.)

☐ Numbness on the face ☐ Double Vision ☐ Blurred Vision

☐ Difficulty Swallowing ☐ Hoarseness ☐ Tongue Weakness ☐ Shoulder Weakness

NAME:_____ **Date of Birth:**_____/_____/_____

Past Medical History: Circle any of the following medical conditions that you have or have had:

☐ High Blood Pressure

☐ Irregular Heart Beat

☐ Heart Attack

☐ Pacemaker

☐ High Cholesterol

☐ Stroke

☐ Cancer – Type _____

☐ TMJ

☐ Thyroid Disease

☐ Sleep Apnea or CPAP

☐ Emphysema/ COPD

☐ Asthma

☐ Prostate enlargement BPH

☐ Diabetes

☐ Fibromyalgia

☐ Arthritis

☐ HIV/AIDS

☐ Ulcer, Reflux or GERD

☐ Bleeding Problems

☐ Depression or Anxiety

☐ Dialysis or Renal Failure

☐ Seizures or Convulsions

Other: _____

Have you had any previous serious injury? Please describe:

_____

_____

_____

Have you had any surgeries other than ear surgery?

_____

_____

_____

NAME:_____ **Date of Birth:**_____/_____/_____

Medications: List below the medications you are taking. Please include prescription and over the counter medications such as aspirin, cold medicines or antihistamines . (If possible bring your meds with you or a current list.)

Medication:	Dose	How Often	Why do you take this?

Do you take Vitamins and Supplements? ☐ Yes ☐ No PLEASE DO NOT LIST

Allergies: Are you allergic to any medications? ☐ Yes ☐ No
If so, please list and check the reaction you experience:

Medication:	Breathing Difficulty	Rash	Other (nausea)
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Are you allergic to latex? ☐ Yes ☐ No

Please list your pharmacy: Name: _____

Phone: _____

Address: _____

Crossroads: _____

MAIL ORDER: ☐ Medco ☐ Caremark ☐ Express Scripts, Inc
☐ Pharmacare ☐ Other

NAME:_____ **Date of Birth:**_____/_____/_____

Family History: What medical problems run in your family?

Father: _____

Mother: _____

Other : _____

Social History:

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes a day? _____

Are you a former smoker? ☐ Yes ☐ No
If yes when did you quit. _____

Do you drink alcohol? ☐ Yes ☐ No
If yes how many drinks per day? ___

Have you had problems with alcoholism? ☐ Yes ☐ No

Have you had problems with drug abuse? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No

How much salt do you eat daily? For example processed food is high in salt.
☐ High ☐ Average ☐ Low

Any information related to your medical care is confidential and will not be released without your permission. Michigan Ear Institute can give medical information related to your treatment to

_____.

Relationship: _____

Tests results and messages may be left by phone message at _____.

If you need to keep additional physicians updated on your visits, please provide the information on the back. A letter will be sent to your physician(s) from your MEI physician with updates UNLESS you specify that you DO NOT want one sent.

• I, the undersigned, do acknowledge that the information stated above is true. I authorize the Michigan Ear Institute to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to the Michigan Ear Institute. For insurance purposes, I permit a copy of this authorization to be used in place of the original. I do hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered, or those to be rendered to me or to my dependents by the Michigan Ear Institute, regardless of my insurance coverage, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 10%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I understand that there will be a $35 charge for any returned checks. I also authorize the Michigan Ear Institute to release medical information to the above stated physicians. I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician.

SIGNATURE OF PATIENT/LEGAL GUARDIAN_____ **DATE:**_____
Valid for one year)
Relationship to patient: _____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of Michigan Ear Institute, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment

for your care, such as family members or friends. We are not required to agree to your request; how ever, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Michigan Ear Institute, Medical Records, 248-865-4444.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Michigan Ear Institute Medical Records, 248-865-4444. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice contact Michigan Ear Institute Medical Records, 248-865-4444.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Michigan Ear Institute, Practice Administrator, 248-865-4444. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy practices, please contact our administrator or clinical manager at 248-865-4444.

I hereby acknowledge that I have presented with a copy of Michigan Ear Institutes' Notify of Privacy

PRINT NAME OF PATIENT: _____

PATIENT SIGNATURE: _____

DATE: _____

MEI PATIENT REPRESENTATIVE: _____

Michigan Ear Institute, P.L.L.C.

I authorize the Michigan Ear Institute to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to the Michigan Ear Institute. For insurance purposes, I permit a copy of this authorization to be used in place of the original. I do hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered, or those to be rendered to me or to my dependents by the Michigan Ear Institute, regardless of my insurance coverage, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 10% or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I understand that there will be a $25 charge for any returned checks. I also authorize the Michigan Ear Institute to release medical information to any physician I have listed. I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician. I authorize Michigan Ear Institute to obtain medication history from electronic vendor.

For Research Purposes: We may use or disclose your protected health information for research when the use of disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

SIGNATURE OF PATIENT / LEGAL GUARDIAN: _____

PRINT NAME OF PATIENT: _____

DOB: _____

DATE: _____

MICHIGAN EAR INSTITUTE REPRESENTATIVE: _____