MICHIGAN EAR, NOSE, AND THROAT & BLOOMFIELD HEARING

PLEASE PRINT

Date_____

Were you referred by a doctor (Circle) No Yes Dr._____

Patient Name_____ **Age** _____ **Sex M F**

Birthdate_____ **Patient Soc Sec No**_____

Mailing Address_____ **City**_____

State_____ **Zip Code**_____ **Home Phone**_____

Business Phone_____ **Cell Phone**_____

Email address _____

Name of Spouse/Parent_____

Primary Insured's Name_____ **Birthdate**_____

Secondary Insured's Name_____ **Birthdate**_____

Emergency Contact_____**Phone Home/Cell**_____

Relationship_____**Authorized to make medical decisions? Y or N**

Can we contact you at? (Circle) Home Work Both None Other_____

You may share my medical information with? (Circle)

Spouse Ex-Spouse Father Mother Children None Other_____

Can we mail medically relevant information to your home? (Circle) Yes No

Michigan Ear, Nose, and Throat Associates

Otolaryngology – Head and Neck Surgery – Facial Plastic Surgery

Bashar Succar, M.D., F.A.C.S. Sam Bahu, M.D. Melissa Rakowski, D.O.

Welcome to our practice. Please complete all areas:

Date: _____ Patient Name: _____

Referring Physician/Primary Care Physician: _____

Reason for Visit: _____

History of present illness:

* Location: _____ (Where is the pain/problem?)
* Quality: _____ (Example: normal vs. abnormal color, activity, etc.)
* Severity: _____ (How severe is the pain/problem on a scale of 1-5) (Five being the most severe)
* Duration: _____ (How long have you had this pain/problem? or When did it start?)
* Timing: _____ (Does this pain/problem occur at a specific time?)
* Context: _____ (Where were you at the onset of this pain/problem?)
* Associated signs/symptoms: _____ _____ (What other associated problems have you been having?)
* Modifying factors: _____ _____ (What makes the pain/problems worse or better?)

Medical History:

Patient Medical History:

Diabetes	No	Yes
Performed		
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis/Gout	No	Yes
Seizures	No	Yes
Bleeding Tendency	No	Yes
Thyroid Disease	No	Yes
Hepatitis	No	Yes
HIV	No	Yes
Sleep Apnea	No	Yes
Blood Thinner Use	No	Yes

Please List any other medical conditions not noted above:_____

_____

Surgical History:

List Hospitalizations & Surgeries

Date **Surgeon/Hospital/Surgery**

_____

_____

_____

_____

*__MEDICATIONS__: _____

_____

_____

_____

_____

*__MEDICATION ALLERGIES:__ _____

_____

__Date of Last Menstrual Period:__ _____

Patient Social History:

Marital Status: Single: ___ Married: ___ Separated: ___ Divorced:___ Widowed: ___

Use of Alcohol: Never: ___ Rarely: ____ Moderate:____ Daily: _____

Use of Tobacco: Never: ___ Previously, but: Quit:_____ Current packs/day: _____

Use of Illegal Drugs: Never: ___ Type/Frequency: _____ _____ _____

Exposure home or work to: Fumes:____ Dust:_____ Solvents:_____ Air-borne Particles:_____ Noise:_____

Family Medical History:

	Age	Diseases	If deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
	____	_____	_____
Children	____	_____	_____
	____	_____	_____

Over →

Please Circle Pertaining To You

Constitutional Symptoms

Good general health lately……	No	Yes
Recent weight change……	No	Yes
Fever……	No	Yes
Fatigue……..	No	Yes
Headaches……	No	Yes

Cardiovascular

Heart trouble……	No	Yes
Chest pain or angina……..	No	Yes
Palpitation……	No	Yes
Shortness of breath while walking……..	No	Yes
Shortness of breath while lying flat……..	No	Yes
Swelling of feet, ankles, or hands…….	No	Yes

Respiratory

Chronic or frequent coughs……..	No	Yes
Spitting up blood……	No	Yes
Asthma or wheezing……..	No	Yes

Eyes

Eye disease or injury……	No	Yes
Wear glasses/contact lenses……	No	Yes
Blurred or double vision……	No	Yes
Glaucoma……	No	Yes

Endocrine

Hormone Problem……..	No	Yes
Thyroid disease……	No	Yes
Diabetes……..	No	Yes
Excessive thirst or urination……..	No	Yes
Heat or cold intolerance……	No	Yes
Skin becoming dryer……..	No	Yes

Allergic/Immunologic

History of skin reaction/or other adverse reaction to:

Penicillin or other antibiotics……	No	Yes
Morphine/Demerol/other narcotics……..	No	Yes
Novocaine or other anesthetics……	No	Yes
Aspirin or other pain remedies……	No	Yes
Tetanus antitoxin or other serums……	No	Yes
Iodine, methiolate/other antiseptic……	No	Yes
Latex Allergy	No	Yes

List Other Allergies: _____

_____

Gastrointestinal

Loss of appetite……..	No	Yes
Change in bowel movement……	No	Yes
Nausea or Vomiting……	No	Yes
Frequent diarrhea……..	No	Yes
Painful bowel movement……	No	Yes
Constipation……	No	Yes
Rectal bleeding/blood in stool……	No	Yes
Abdominal pain or heartburn……	No	Yes
Peptic ulcer (stomach)……	No	Yes

Integumentary (skin)

Rash or Itching…….	No	Yes
Change in skin color……..…	No	Yes
Change in hair or nails……	No	Yes
Varicose Veins……..	No	Yes

Neurological

Frequent/recurring headaches……	No	Yes
Light headed or dizzy……..	No	Yes
Convulsions or Seizures……..	No	Yes
Numbness/tingling sensation……..	No	Yes
Tremors……	No	Yes
Paralysis……..	No	Yes
Stroke……..	No	Yes
Head Injury……..	No	Yes

Psychiatric

Memory loss or confusion……...	No	Yes
Nervousness…….	No	Yes
Depression……	No	Yes
Insomnia (sleeplessness)……..	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing…….	No	Yes
Earaches or drainage……...	No	Yes
Chronic sinus problem……..	No	Yes
Nose bleeds……...	No	Yes
Mouth sores……	No	Yes
Bleeding gums……	No	Yes
Sore throat or voice change…….	No	Yes
Swollen glands in neck…….	No	Yes

Genitourinary

Frequent urination……	No	Yes
Burning or painful urination…….	No	Yes
Blood in urine…….	No	Yes
Incontinence or dribbling……..	No	Yes
Kidney stones…….	No	Yes
Sexual difficulties……	No	Yes

Hematological/Lymphatic

Slow to heal after cuts……	No	Yes
Bleeding or bruising tendency……...	No	Yes
Anemia……..	No	Yes
Vein Clots or Phlebitis…….	No	Yes
Past transfusion……	No	Yes
Enlarged glands……	No	Yes

Musculoskeletal

Joint Pain……	No	Yes
Joint stiffness or swelling…….	No	Yes
Weakness of muscles/joints……	No	Yes
Muscle pain or cramps…….	No	Yes
Back pain……	No	Yes
Cold extremities (hand/foot)……	No	Yes
Difficulty in walking……	No	Yes

Michigan Ear, Nose and Throat Associates
Bloomfield Facial Plastic Surgery
Bloomfield Hearing
44200 Woodward Ave.
Suite 201
Pontiac, MI 48341

PATIENT NAME: _____

I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Michigan Ear, Nose, and Throat Associates, Bloomfield Facial Plastic Surgery and Bloomfield Hearing for medical or surgical services rendered, not to exceed the reasonable and customary charges for these services. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges not paid by my insurance.

Signature: _____ Date: _____

I hereby authorize the physicians of Michigan Ear, Nose, and Throat Associates, Bloomfield Facial Plastic Surgery and Bloomfield Hearing to perform upon me or the patient, if not myself, any minor office procedures needed to diagnose and treat my condition including, but not limited, flexible or rigid scope, ear cleaning, biopsies, or the need for any other procedures. Risk may include bleeding, infection, wound healing problems or scar formation. I will have the opportunity to ask any questions prior to a procedure.

Signature: _____ Date: _____

I have been given the opportunity to review and may choose to take home a copy of the Michigan Ear, Nose, and Throat Associates, Bloomfield Facial Plastic Surgery and Bloomfield Hearing Notice of Privacy Practices.

Signature: _____ Date: _____

If person signing is not patient, please print name below and relationship to patient:

_____ _____

Printed Name Relationship to Patient

Michigan Ear Nose and Throat Associates
Bloomfield Facial Plastic Surgery
Bloomfield Hearing

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

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 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 the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of the 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 custody of a law enforcement official.

8. For Worker's Compensation and similar programs.

9. Michigan Ear, Nose and Throat Associates, Bloomfield Facial Plastic Surgery and Bloomfield Hearing are incorporated and will exchange information freely.

10. Michigan Ear, Nose and Throat, Bloomfield Facial Plastic Surgery and Bloomfield Hearing will be sharing your medical information with other providers as appropriate.

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 discloser of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, 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 the physician who is primarily caring for you at Michigan Ear, Nose and Throat Associates or the Office Manager if you are not being followed by a physician.

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 the physician who is primarily caring for you at Michigan Ear, Nose and Throat Associates or the Office Manager if you are not being followed by a physician. 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 our front desk receptionist.

6. Right to file a complaint. If you believe your privacy right 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 the physician who is primarily caring for you at Michigan Ear, Nose and Throat or the Office Manager if you are not being followed by a physician. 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.