ASC AUDIOLOGICAL SERVICES OF CADILLAC HEARING CLINIC

8872 Professional Dr., Suite A
Cadillac, Michigan 49601

Phone: 231-775-9398
Toll Free: 1-877-775-9398
Fax: 231-775-2717

Dr. Kelly M. Pendrick
Audiologist

Dr. Amie M. Ruppert
Audiologist

Dear Patient,

Your appointment with us is on _____
with _____.

Please complete the enclosed forms and bring them with you to your appointment, along with your current insurance cards and driver's license. A parent or legal guardian MUST accompany all minors to their appointment.

Kindy give our office a 24-hour notice if you have to reschedule. If you fail to keep this scheduled appointment we reserve the right to NOT reschedule a future appointment.

Feel free to contact us with any questions or concerns at (231) 775-9398 or toll free at (800) 775-9398.

We thank you for choosing Audiological Services of Cadillac for you hearing health care needs.

Cadillac E.N.T. & Facial Plastic Surgery
Robert Kendell, D.O., P.C.
Lisa Jacobson, D.O., P.C.
8872 Professional Dr., Suite A
Cadillac, MI 49601
(231) 779-6260 Fax (231) 779-6264

Audiological Services of Cadillac, Inc.
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PATIENT HEALTH HISTORY FORM

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Last Name:_____ **First Name:**_____ **Middle Initial:**___

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Social Security Number:_____ **Employer of Patient or Guardian:**_____

Home Phone: ( ) ____-_____ **Work Phone:** ( ) ____-_____ **Cell Phone:** ( ) ____-_____

Email:_____ **Sex:** ☐ Male ☐ Female **Date of Birth:**___/___/____

Name of Primary Care Physician:_____

Referring Physcian:_____

Guardian, if Patient is a Minor:_____

Employer of Patient or Guardian:_____

INSURANCE INFORMATION

Primary Ins. Company:_____ **Subscriber:**_____

Date of Birth:___/___/____ **Social Security Number:** ____-____-____ **Relationship to Patient:**_____

Secondary Ins. Company:_____ **Subscriber:**_____

Date of Birth:___/___/____ **Social Security Number:** ____-____-____ **Relationship to Patient:**_____

AUTHORIZATION TO RELEASE INFORMATION

Please list those people who we may discuss your <u>medical</u> information with: _____

_____

_____

Please list those people who we may discuss your <u>financial</u> information with:_____

_____

_____

***I acknowledge that I have had the full opportunity to receive & read the Office Policy Regarding Insurance Payment and Reimbursement from Audiological Services of Cadillac, Robert Kendell, D.O., P.C. and Lisa Jacobson D.O., P.C.**

Patient/Guardian Signature:_____ **Date:**___/____/_____

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MEDICATION INFORMATION

Patient Name:_____

Pharmacy Preference (please include location): _____

_____

Height:_____ **Weight:**_____

REASON FOR TODAY'S VISIT:_____

PLEASE LIST ANY MEDICATIONS/SUPPLEMENTS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How often taken

*If you need more room, please use back of this sheet.

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____Yes ____No If yes, please explain below.

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Please list any surgeries you have had including dates:

Type of Surgery	Date	Type of Surgery	Date

Patient/Guardian Signature:_____ **Date:**____/____/_____

Patient Health History

36-1897012

Marking Instructions

- ~~Use only a number 2 pencil.~~
- Fill in the complete oval as shown below.
- Fill in date on the line when MM/YR is present.

Correct Mark ● Incorrect Marks ⊘ ✓ ✗

Name: _____

Date of Appt: _____

1. Race *(Mark Only One)*

American Indian or Alaskan Native	○	Native Hawaiian or Other Pacific Islander	○
Asian	○	Some Other Race	○
Black or African American	○	White	○
Decline to State	○		

2. Ethnicity *(Mark Only One)*

Decline to State	○	Not Hispanic or Latino	○
Hispanic or Latino	○		

3. Preferred Language *(Mark Only One)*

English	○	Spanish	○

4. Preferred method of receiving office reminders *(Mark Only One)*

Opt Out	○	Home Fax	○
Home Phone	○	Work Fax	○
Work Phone	○	Mail	○
Mobile Phone	○	Patient Portal	○
Other Phone	○		

5. Food Allergies or Intolerances

	Yes		Yes
Eggs	○	Yeast – Baker's	○

6. Cancers

	Date Diagnosed	Yes
Bladder	MM / YR	○
Bone	MM / YR	○
Brain	MM / YR	○
Breast	MM / YR	○
Cervical	MM / YR	○
Colon	MM / YR	○
Esophagus	MM / YR	○
Ewing's Sarcoma	MM / YR	○
Hodgkin's Disease	MM / YR	○
Kaposi Sarcoma	MM / YR	○
Kidney	MM / YR	○
Larynx	MM / YR	○
Leukemia	MM / YR	○
Liver	MM / YR	○
Lung	MM / YR	○
Lymphoma	MM / YR	○
Multiple Myeloma	MM / YR	○
Ovarian	MM / YR	○
Pancreas	MM / YR	○
Pheochromocytoma	MM / YR	○
Polycythemia Vera	MM / YR	○
Prostate	MM / YR	○
Rectum	MM / YR	○
Skin – Basal Cell	MM / YR	○

6. Cancers *(continued)*

	Date Diagnosed	Yes
Skin – Malignant Melanoma	MM / YR	○
Skin – Squamous Cell	MM / YR	○
Skin – Unknown Type	MM / YR	○
Stomach	MM / YR	○
Testicular	MM / YR	○
Throat	MM / YR	○
Thyroid	MM / YR	○
Uterine	MM / YR	○

7. Past Health History

	Date Diagnosed	Yes
High Blood Pressure (Hypertension)		○
~~Pregnant – Pregnancy Has Been Confirmed~~		○
Encephalopathy		○
Neuralgia		○
Neuritis		○
Paralysis		○
Progressive Neurologic Disorder		○
Radiculitis		○
Intravenous Drug Abuse		○
Autoimmune Disorder		○
HIV Positive (Asymptomatic)		○

8. Past Surgeries

	Procedure Date	Yes
Colectomy – Total		○
Colonoscopy	MM / YR	○
Hysterectomy		○
Mastectomy – Details Unspecified		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Modified Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Radical		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○
Mastectomy – Simple		Yes
Left Separate		○
Right Separate		○
Both at Same Time		○

EXAMPLE TO FILL IN DATES

If you have had paralysis in December of 1990, fill in the oval and write the date as shown below.

Paralysis 12/90 ●

1897012

1897012

LP2585_MU

Patient Health History

26 - 2471201

Marking Instructions

- ~~Use only a number 2 pencil.~~
- **Fill in the complete oval as shown below.**

Correct Mark ● **Incorrect Marks** ⊘ ✓ ✗

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Seafood	○
Latex	○	Contrast Dye	○

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	○	Gastrointestinal Reflux	○
Lung Cancer	○	Hepatitis	○
Skin Cancer	○	Stomach Ulcer	○
Throat Cancer	○		
Prostate Cancer	○		
Other Cancer	○	Are you pregnant?	○
		Prostate Enlargement	○
Migraine Headache	○	Renal Failure	○
Cataracts	○	Stroke	○
Glaucoma	○		
		Anxiety	○
Nasal Allergies	○	Depression	○
Sleep Apnea	○	Diabetes	○
		Thyroid Dysfunction	○
Blood Clots/DVT	○		
High/Elevated Cholesterol	○	Anemia	○
		Hemophilia	○
Heart Attack	○		
High Blood Pressure	○	HIV	○
Asthma	○		
Chronic Bronchitis	○		
Emphysema	○		
Tuberculosis	○		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	○	○	○	○	○
Thyroid Cancer	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Unspecified Cancer	○	○	○	○	○
Hearing Loss before age 20	○	○	○	○	○
Hearing Loss after age 20	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Asthma	○	○	○	○	○
Stroke	○	○	○	○	○
Diabetes	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

4. Mark if retired. Yes ○

5. Tobacco Use:

Mark your tobacco use.

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

○ Less than 12 drinks/yr
○ 1-13 drinks/mo
○ 4-14 drinks/wk
○ >2 drinks/day

6. Do you use drugs recreationally? Yes ○

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

○ None ○ 2-3 per day
○ 1 per day ○ 4 or more

8. Are you exposed to second hand smoke? Yes ○

9. Mark if patient attends daycare. Yes ○

10. Will you accept transfusion of blood products if necessary? Yes ○

11. Home Living Situation (mark all that apply).

○ Alone ○ With spouse
○ With children ○ In nursing home
○ With mother ○ With father
○ In assisted living ○ Other

2471201

2471201

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Michigan Hearing Systems, Inc.
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OFFICE POLICY REGARDING INSURANCE PAYMENT AND REIMBURSEMENT

Please check with your insurance company regarding your coverage prior to your appointment. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. If you have any questions about the information below, please do not hesitate to ask. We are committed to providing you with the best possible care and service.

Blue Cross Blue Shield/Blue Care Network: We participate with Blue Cross Blue Shield/Blue Care Network. However, you are responsible for your co-pay and/or deductible per your policy; which is due at the time of service, unless prior arrangements are made. ** Please note, Audiological Services of Cadillac and Michigan Hearing Systems participate only with those contracts that are hearing/hearing aid eligible and where hearing aids are recommended.

PPOM's: We participate with PPOM. However you are responsible for your co-pay and/or deductible at the time of service.

Priority Health: We participate with Priority Health. However you are responsible for your co-pay and/or deductible at the time of service.

Medicare: We participate with Medicare. However, you are responsible for your co-pay and/or deductible at the time of service.

Medicaid: We participate with **straight** Medicaid only.

Commercial Carriers: We will submit claims to your insurance carrier if all information is provided, however, this is **not** a guarantee of payment. Your co-pay and/or deductible are due at the time of service.

Auto Insurance: We will submit all claims incurred if **you** provide company name, address, and claim number. Otherwise, payment in full is expected at the time of service.

Worker's Compensation: We **must** receive written authorization from your compensation carrier on/or before your appointment. Otherwise, payment in full is expected at the time of service.

Appointments: We **REQUIRE** a minimum 24-hour notice for cancelled appointments. If 24-hour notice is not given you may be responsible for the usual and customary amount we bill for that visit.

Self-Pay/No Ins: It is **YOUR** (patient/guardian) responsibility to call our office before your appointment to find out what the cost will be for your visit. This amount will be collected prior to seeing the doctor.

I acknowledge that I have read and understand the above insurance policy. Furthermore, any charges incurred not covered by my insurance are my sole responsibility to pay in full. I am responsible for an additional charge of 32% should my account go to an outside collection agency or in house collections.