

8872 Professional Dr., Suite A Cadillac, Michigan 49601

Phone: 231-775-9398 Toli 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:	<u> </u>		Middle Initial:
Address:	City:		State:	Zip:
	Employer of P			
	Work Phone: (
	Sex			•
Name of Primary Care Phy	/sician:			
Referring Physcian:				
Guardian, if Patient is a M	inor:			
	ardian:			
	INSURANCE IN		•	
Primary Ins. Company:	S	Subscriber:		
	Social Security Number:			
				•
	Social Security Number:			
	AUTHORIZATION TO REI			
Please list those people who	we may discuss your <u>medical</u> in	formation with:		
Please list those people who	we may discuss your <u>financial</u> i	nformation with:		
*I acknowledge that I have had Reimbursement from Audiolog	the full opportunity to receive & rical Services of Cadillac, Robert K	ead the Office Policy Reendell, D.O., P.C. and L	garding Insurar	nce Payment and D., P.C.
Patient/Guardian Signature:			Date:	1 1

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MEDICATION INFORMATION

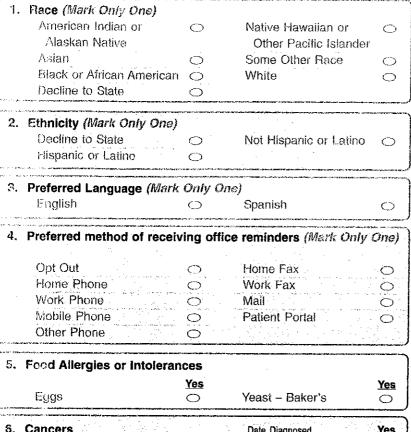
Height: Weigh	t:		
REASON FOR TODAY'S VIS	SIT:		
PLEASE LIST ANY MEDICA		YOU ARE CURRENTLY TAKIN	G:
Name of Medication	Dosa	age He	ow often taken
			
			· · · · · · · · · · · · · · · · · · ·
RE YOU ALLERGIC TO AN	NY MEDICATIONS?	YesNo If yes, please ex	plain below.
RE YOU ALLERGIC TO AN Name of Medica	NY MEDICATIONS?	YesNo If yes, please ex Type of Reaction	
RE YOU ALLERGIC TO AN Name of Medica URGERIES AND HOSPITAI ease list any surgeries you have Type of Surgery	LIZATIONS:		

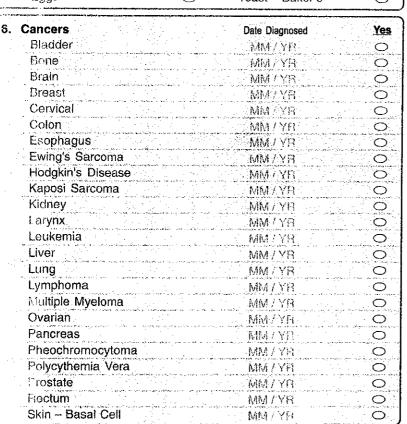
Patient Health History

Marking Instructions

- tise only a number 2 pencil.
- Fill in the complete oval as shown below.

ill in date on the	line when MM/YR is pre		
Correct Mark 👛	Incorrect Marks 🗀	W	\X >







Name:		
Date of Appt:		
6. Cancers (continued)	Date Diagnosed	Yes
Skin - Malignant Melanoma	a was street	\bigcirc
Skin – Squamous Cell	1.55 A 1.55	\bigcirc
Skin – Unknown Type	Table Vis	\circ
Stomach	Cat/yis i	\bigcirc
Testicular	WHAT IN	\bigcirc
Throat	est ys	\circ
Thyroid		$\dot{\circ}$
Uterine	MANAMI	\circ
Uterine 7. Past Health History	Date Diagnosed	○ <u>Yes</u>
7. Past Health History	-	na man nan n
7. Past Health History High Blood Pressure (Hypert	ension)	<u>Yes</u>
7. Past Health History	ension)	Yes
7. Past Health History High Blood Pressure (Hypert Pregnant – Pregnancy Has Be	ension)	Yes
7. Past Health History High Blood Pressure (Hypert Pregnant - Pregnancy Has Be Encephalopathy	ension)	Yes
7. Past Health History High Blood Pressure (Hypert Pregnant - Pregnancy Has Be Encephalopathy Neuralgia	ension)	Yes () () () () () () () () () () () () ()
7. Past Health History High Blood Pressure (Hypert Pregnant - Pregnancy Has Be Encephalopathy Neuralgia Neuritis Paralysis	ension) en Confirmed	Yes 0 0 0 0 0 0 0
7. Past Health History High Blood Pressure (Hypert Pregnant - Pregnancy Has Be Encephalopathy Neuralgia Neuritis	ension) en Confirmed	Yes
7. Past Health History High Blood Pressure (Hypert Pregnant - Pregnancy Has Be Encephalopathy Neuralgia Neuritis Paralysis Progressive Neurologic Disorde	ension) en Confirmed	Yes 0 0 0 0 0 0 0
7. Past Health History High Blood Pressure (Hypert Pregnant - Pregnancy Has Be Encephalopathy Neuralgia Neuritis Paralysis Progressive Neurologic Disorde Radiculitis	ension) en Confirmed	Yes 0 0 0 0 0 0 0

8.	Past Surgeries Procedure Date	<u>Yes</u>
n de	Colectomy - Total	0
	Colonoscopy MM/YR	0
	Hysterectomy	0
	Mastectomy - Details Unspecified	Yes
	Left Separate	0
÷	Right Separate	0
	Both at Same Time	\circ
	Mastectomy - Modified Radical	Yes
	Left Separate	0
	Right Separate	0
	Both at Same Time	0
	Mastectomy - Radical	Yes
	Left Separate	0
	Right Separate	0
	Both at Same Time	Ö
À	Mastectomy - Simple	Yes
	Left Separate	
	Right Separate	0
-	Both at Same Time	0

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

Patient Health History

Marking Instructions

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

Correct Mark

Incorrect Marks 🕥





	Adhesive tape lodine Latex	<u>Yes</u> O O	Metal Seafood Contrast Dye	Ye
٨	lark if you have been di		with any of the following:	
	Breast Cancer	<u>Yes</u>	Castusintantinal	<u>Ye</u>
	Lung Cancer		Gastrointestinal Reflux	
	Skin Cancer	. 0	Hepatitis	\subseteq
	Throat Cancer	·	Stomach Ulcer	ب
	Prostate Cancer		Stomach Older	<u>_</u>
	Other Cancer		Are you pregnant?	
			Prostate Enlargement	
	Migraine Headache	0	Renal Failure	\subset
		. —		
	Cataracts	. 0	Stroke	\subset
	Glaucoma		The winds of the second second	
			Anxiety	
	Nasal Allergies	0	Depression	C
	Sleep Apnea		Diabetes	
			Thyroid Dysfunction	<u> </u>
	Blood Clots/DVT			
	High/Elevated		Anemia	\subset
	Cholesterol	0	Hemophilia	
	Heart Attack	<u> </u>		
	High Blood Pressure	0	HIV	\subset
	Asthma	<u> </u>		
	Chronic Bronchitis		•	
	Emphysema			
	Tuberculosis	\circ		

the following:		•	.	,	
	None	<u>Mother</u>	<u>Father</u>	Brother	Sister
Problems with Anesthesia	0	0	0	0	0
Thyroid Cancer	0	0	0	0	0
Lung Cancer		0		0	0
Unspecified Cancer	0			0	
Hearing Loss before age 2	00	0	0	0	0
Hearing Loss after age 20	0	0	0	0	
Heart Disease				0	
High Blood Pressure		0	0	0	\circ
Asthma	\circ	0		0	
Stroke					
Diabetes	\circ	0	0	0	0
Bleeding/Clotting Problem	\circ	0	0	0	0



	Na	me:	•
	Da	te of Appt:	
- (4.	Mark if retired.	<u>Yes</u>
	5.	Tobacco Use: Mark your tobacco use. None Smokeless Tobacco	○ Cigarettes○ Cigars
		Give the closest amount smoke in an average date of 1/2 pack of 1 pack of 1/2 packs	
		Alcoholic Beverages - A liquor or 1 glass of wine or Cless than 12 drinks/yr 1-13 drinks/mo 4-14 drinks/wk >2 drinks/day	1 bottle/can of beer.
	6.	Do you use drugs recre	ationally? Yes
- (O
	7.	Caffeine Use (coffee, tea other caffeinated drinks): None 1 per day	0
-	7 .	other caffeinated drinks): O None	, chocolate, cola, 2-3 per day 4 or more
-		other caffeinated drinks): None 1 per day	chocolate, cola, 2-3 per day 4 or more cond hand smoke? Yes
	8.	other caffeinated drinks): None 1 per day Are you exposed to second	chocolate, cola, 2-3 per day 4 or more ond hand smoke? Yes aycare. Yes

2471201

2471201

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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.

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

<u>Medicare:</u> 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.

<u>Commercial Carriers:</u> 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.

<u>Auto Insurance:</u> We will submit all claims incurred if <u>you</u> 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.

<u>Self-Pay/No Ins</u>: It is <u>YOUR</u> (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.