



MICHIGAN PEDIATRIC  
EAR, NOSE, AND THROAT ASSOCIATES

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Dear Patient,

Welcome to Michigan Pediatric Ear, Nose, & Throat Associates!

Our doctors and support staff are dedicated to making sure your experience in our office is one that you will be pleased with.

To help us ensure that your first visit goes smoothly, please take a few minutes to fill out the registration and history forms completely. It is very important that the parent accompanies the child to the first office visit so that an accurate medical history can be obtained and the doctor can explain the plan of care at the time of visit.

It is of the utmost importance that you arrive at your scheduled appointment time to complete the registration process; any tardiness on your part will delay your appointment.

Lastly, please remember to bring the following with you to your appointment:

- **Picture ID**-Birth Parent or Legal Guardian
- **Insurance Cards**-ALL insurance cards **must** be presented to ensure proper billing
- **Insurance Co-Pay**-**ALL** co-payments required by your insurance company each time you visit the office for any service. Payment is always expected at the time of service and will be collected when you check in for your appointment.
- **Insurance Referral**-If you have Blue Care Network, HAP HMO through Henry Ford, Tri-Care Prime or Health+, you will need to get a referral from your PCP for your office visit. If you do not have a referral, your appointment will need to be rescheduled.
- **Test Results**-If you have any reports or results that would help the doctor with your office visit, please make sure to bring a copy for review at your appointment.
- **Proof of Guardianship**-If you have a foster child or are not the birth parent of the child, please bring a note from the birth parent or your guardianship papers

**If you are unable to make your scheduled appointment, please give the office a call as soon as possible**

If you need to cancel or reschedule your appointment, please call (248) 571-3600.

See You Soon!

**Clinton Township**

42645 Garfield, Suite 109  
Clinton Township, MI 48038  
248-571-3600  
Fax 586-416-1712

**West Bloomfield**

7001 Orchard Lake Road, Suite 320C  
West Bloomfield, MI 48322  
248-571-3600  
Fax 248-973-8560

**If you require a translator for your visit, please contact the office prior to your appointment.  
Thank You**

# MICHIGAN PEDIATRIC ENT PATIENT REGISTRATION FORM

**PEDIATRICIAN**

DOCTOR NAME: \_\_\_\_\_ PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PHARMACY :** \_\_\_\_\_ PHONE: \_\_\_\_\_  
 (NAME & LOCATION)

**PATIENT NAME:** \_\_\_\_\_ SEX: M / F BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

**MOTHERS NAME:** \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_ DOES PATIENT LIVE WITH YOU? YES / NO

**FATHERS NAME:** \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_ DOES PATIENT LIVE WITH YOU? YES / NO

\*\*\*\*\* IF DIFFERENT THAN PARENT \*\*\*\*\*

**LEGAL GUARDIAN:** \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DOES PATIENT LIVE WITH YOU? YES / NO

\*PLEASE PROVIDE ALL LEGAL PAPERWORK FOR RECORDS

PATIENTS PRIMARY INSURANCE: \_\_\_\_\_ CONTRACT NO: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

PATIENTS SECONDARY INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

**\*\*PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND PHOTO ID TO COPY. THANK YOU \*\***

I authorize the release of any information pertinent to my case to any insurance company which is necessary to process my medical claims for any service rendered. I permit a copy of this authorization to be used in place of the original. I understand I am responsible for any changes not covered by my insurance company. I also permit the release of information to my primary care physician or a physician MPENTA may refer my child to for follow up.

\_\_\_\_\_  
 Signature of Parent / Guardian Date: \_\_\_\_\_

\_\_\_\_\_ no change in information Date: \_\_\_\_\_  
 initials



# HEALTH HISTORY QUESTIONNAIRE

**Name** \_\_\_\_\_  M  F

**Date of Birth** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

**Email** \_\_\_\_\_

**Language**       Arabic       English       Spanish       Other       Decline to Answer

**Ethnicity**       Arab Decent       Hispanic/Latino       Other       Unknown       Decline to Answer

**Race**       African American       American Indian       Asian       Caucasian  
 Native American       Other       Unknown       Decline to Answer

**Pharmacy** \_\_\_\_\_ **Phone** \_\_\_\_\_

**PCP/Pediatrician** \_\_\_\_\_ **Phone** \_\_\_\_\_

## PREVIOUS STUDIES

**Has your child had any previous studies done?**       Blood Work       Bone Scan       CT Scan  
 EMG       MRI       Sleep Study       Ultrasound       X Ray       Other

**Where did you have testing done?**

**Have you traveled outside of the US in the past 3 weeks?**       Yes       No

**Reason for visit today?**

\_\_\_\_\_

**When did you first notice this problem?**      2 days ago      2 weeks ago      1 month ago      >1 month

## ALLERGIES

Allergic To	Reaction

No Known Allergies

## MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Not currently taking any Medications

## PERSONAL HEALTH HISTORY

Check ALL Conditions that apply to your child (current and past)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Throat Infections        | <input type="checkbox"/> Heart Murmur        |
| <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Nose Bleeds             | <input type="checkbox"/> Hoarseness               | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Ringing in Ears         | <input type="checkbox"/> Congestion              | <input type="checkbox"/> Frequent Clearing Throat | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Popping in Ears         | <input type="checkbox"/> Sneezing                | <input type="checkbox"/> Asthma/Wheezing          |  |
|  | <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Persistent Cough         | <input type="checkbox"/> Sleep Apnea         |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Facial Pain             | <input type="checkbox"/> Swollen Glands           | <input type="checkbox"/> Poor Sleep Quality  |
| <input type="checkbox"/> Fainting                | <input type="checkbox"/> Dental Pain             |   | <input type="checkbox"/> Gasping             |
| <input type="checkbox"/> Seizure Disorder        |  | <input type="checkbox"/> Spitting Up              | <input type="checkbox"/> Irritable           |
|  | <input type="checkbox"/> Cleft Lip               | <input type="checkbox"/> Failure to Thrive        | <input type="checkbox"/> Insomnia            |
| <input type="checkbox"/> Speech Delay            | <input type="checkbox"/> Cleft Palate            | <input type="checkbox"/> Stridor                  | <input type="checkbox"/> Snoring             |
|  |  | <input type="checkbox"/> GERD                     |  |
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Sickle Cell Anemia      | <input type="checkbox"/> Poor Eating Habits       | <input type="checkbox"/> Jaundice            |
| <input type="checkbox"/> Migraine                | <input type="checkbox"/> Bruising Easily         |   |  |
|  | <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> Blurred Vision           | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Meningitis              |  | <input type="checkbox"/> Change in Vision         | <input type="checkbox"/> Thyroid Disease     |

## PAST SURGICAL HISTORY

Surgery	Date	Hospital
<input type="checkbox"/> Tubes		
<input type="checkbox"/> Tonsillectomy		
<input type="checkbox"/> Adenoidectomy		

# FAMILY MEDICAL HISTORY

Check the box for any illness family members have or have had

	ADD/ADHD	Allergies/Asthma	Anemia	Autism	Blood Clotting Problems	Cancer	Diabetes	Ear Infections	Genetic Disease	Hearing Loss	Heart Problems	High Blood Pressure	High Cholesterol	Seizures	Sickle Cell	Stroke	Thyroid Disease
Mother																	
Father																	
Sister																	
Brother																	
Maternal Aunt																	
Maternal Uncle																	
Paternal Aunt																	
Paternal Uncle																	
Maternal Grandmother																	
Maternal Grandfather																	
Paternal Grandmother																	
Paternal Grandfather																	

## SOCIAL HISTORY

Is your child in daycare?     Yes     No   
 Current grade in school? \_\_\_\_\_  
 Does your child have any siblings?     No     Yes   
 \_\_\_\_\_ brother(s)    \_\_\_\_\_ sister(s)  
 Who does your child live with?     Mom     Dad     Step-Mom     Step-Dad     Other \_\_\_\_\_  
 Are there any pets in your home?     No     Yes   
 \_\_\_\_\_ cat(s)    \_\_\_\_\_ dog(s) \_\_\_\_\_  
 Does anyone smoke in the child's home?     Yes     No     Outside  
 Are immunizations up to date?     Yes     No   
 Do you use seatbelts?     Yes     No

## BIRTH HISTORY

Type of Delivery     Vaginal     Cesarean   
 Weight at Birth \_\_\_\_\_  
 Newborn Feeding     Breastfed     Bottle Fed- Formula   
  Bottle Fed- Breast Milk     Unknown

Are there any other concerns that you would like to discuss with the Doctor at your visit today?


Signature

Relationship to Patient

Date

# INSURANCE REFERRALS AND AUTHORIZATIONS

## **OFFICE VISIT**

If you have any of the following insurances, an authorization number **MUST** be obtained from your Primary Care Physician (PCP) for an office visit prior to being seen in the office

**\*\*If you do not have your referral at the time of your appointment you will be asked to reschedule\*\***

- Aetna HMO
- Blue Care Network HMO
- HAP HMO (Henry Ford Network only)
- Harbor Health HMO (Dr Thottam Dr Bangiyev only)
- Health Plus of Michigan HMO
- Humana HMO
- Priority Health HMO (State of Michigan)
- Tricare Prime
- United HealthCare (select plans)

## **AUDIOLOGY**

***If your insurance has a deductible, you may be responsible to pay out of pocket***

If you have any of the following insurances, a separate authorization number **MUST** be obtained from your Primary Care Physician (PCP) before any hearing related services can be rendered

- Aetna HMO
- Blue Care Network HMO
- Care Choices HMO
- Cigna HMO
- HAP HMO (Henry Ford Network only)
- Health Plus of Michigan HMO
- Medicare Advantage (type B Plans)
- Priority Health HMO (not PPO)
- ProCare
- Tricare Prime

The authorization **MUST** contain the following codes:

### **Provider**

Michigan Pediatric ENT  
NPI 1679631360

### **Diagnosis Code**

H65.493  
Other Chronic Non Supportive Otitis Media Bi-Laterally

### **Procedure Codes**

- \* 92557 Audiologic Evaluation, Comprehensive
- \* 92567 Tympanometry
- \* 92586 Limited (non-sedated) ABR
- \* 92588 Evoked Auditory Test-Complete

Please have your PCP office fax the referral to:

**West Bloomfield** 248-973-8560

**Clinton Township**

586-416-1712

# Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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**Note:** If your insurance doesn't pay for **Audiology Services** listed below, you may have to pay.

Some insurances do not cover audiology testing, even some care that you or your health care provider have good reason to think you need. It is possible that your insurance may not pay for the following services:

92556	\$85	Speech Audiometry Threshold w/ Speech Recognition	<b>92567</b>	<b>\$45</b>	<b>Tympanometry</b>
<b>92557</b>	<b>\$110</b>	<b>Comprehensive Audiometry Threshold w/ Speech Recognition</b>	92579	\$125	VRA
92587	\$50	Distortion Product Evoked Otoacoustic Emissions; Limited	92582	\$150	CPA
92583	\$115	Select Picture Audiometry	92585	\$300	ABR

## WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **AUDIOLOGY SERVICES** listed above.

- I **WANT** the Audiology Services listed above. I understand that if my insurance doesn't pay, I am responsible for payment
- I **DO NOT WANT** the Audiology Services listed above
- I **DO NOT REQUIRE** the Audiology Services listed above, my child is not being seen for any ear or hearing related concerns

Signing below means that you have received and understand this notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



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