MICHIGAN PEDIATRIC
EAR, NOSE, AND THROAT ASSOCIATES

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Clinton Township	West Bloomfield
42645 Garfield, Suite 109	7001 Orchard Lake Road, Suite 320C
Clinton Township, MI 48038	West Bloomfield, MI 48322
248-571-3600	248-571-3600
Fax 586-416-1712	Fax 248-973-8560

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

Failure to show up for a scheduled appointment will result in a No Show fee of $25

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

See You Soon!

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.

_____ Date: _____

Signature of Parent / Guardian

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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)

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

PAST SURGICAL HISTORY

Surgery	Date	Hospital
☐ Tubes		
☐ Tonsillectomy		
☐ 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 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

IT IS THE PATIENTS RESPONSIBILITY TO OBTAIN THE REFERRAL/AUTHORIZATION

Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: _____ **Date of Birth:** _____

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	**92567**	**$45**	**Tympanometry**
92557	**$110**	**Comprehensive Audiometry Threshold w/ Speech Recognition**	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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