ENT CONSULTANTS

OTOLARYNGOLOGY, HEAD & NECK SURGERY

Darryl J. Elzinga, MD
Robert L. Daniels, MD, FACS

Board Certified Physicians
Specializing in the Diagnosis, Surgical and Medical Treatment of Diseases of the Ear, Nose & Throat, Head & Neck.

AUDIOLOGY SERVICES

Nora Lignell, M.A., CCC-A
Tammy Thelen, Au.D., CCC-A
Cheryl Henderson, M.A., CCC-A

Audiology
Vestibular / Neurodiagnostics
- ENG
- OAE
- ABR
- ECOG

Hearing Aids
BAHA Implants

Dear New Patient,

Please allow us to welcome you to our family of patients. We are delighted that you have chosen us to care for your medical needs.

Our office is committed to providing excellent care to our patients. We believe our patients deserve the most comprehensive and up to date care possible, given in a respectful and trusting environment.

We respect the value of your time and will make every effort to be punctual. We will appreciate the same courtesy. Due to surgeries and emergency patients our schedule will sometimes run late. We will always try to keep you updated if we are running behind.

Please keep in mind that we are a specialty office and your appointment is for a specific condition. If you have concerns unrelated to that condition, you may need to see your primary care physician or schedule an additional appointment in our office.

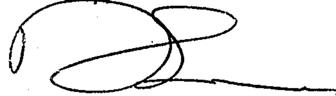
If you have medical benefits you will need to bring your benefits card with you to each appointment. Co-payments and patient balances are due at the time of service.

We ask if you need to reschedule your appointment you give our office a 48 hour notice so the appointment time can be offered to a waiting patient. Appointments that are cancelled on short notice or no showed may incur a charge for the appointment time.

Please complete both sides of the enclosed health forms and kindly bring them with you to your first appointment.

If you have any questions or concerns, please feel free to contact our office. We look forward to meeting you soon.

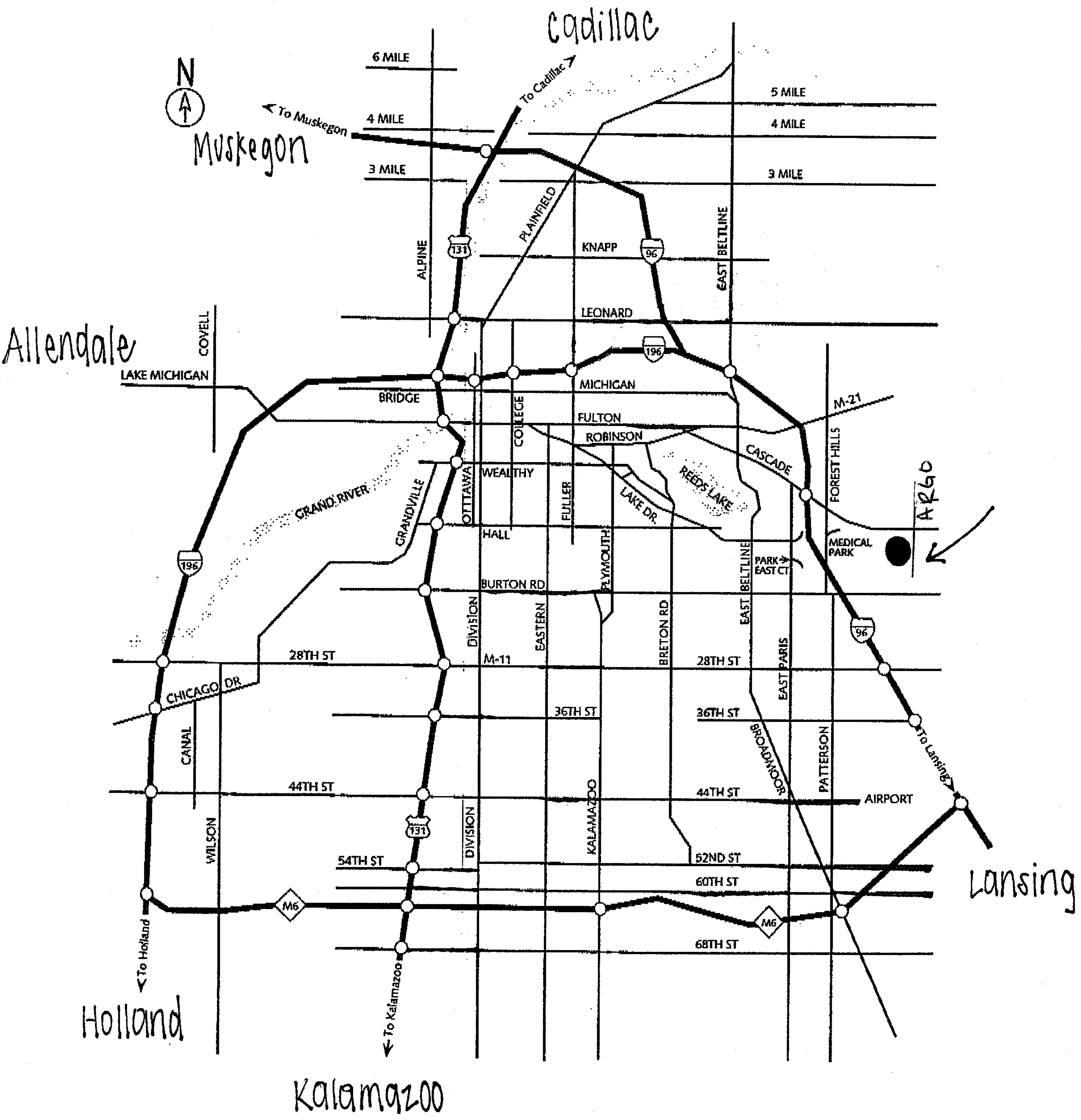
Sincerely,



Dr. Darryl Elzinga

Dr. Robert Daniels

4880 Cascade Rd.
Grand Rapids, MI 49546
Phone: (616) 954-9300
Fax: (616) 954-9543



Cadillac
N
Muskegon
To Muskegon
To Cadillac
6 MILE
5 MILE
4 MILE
3 MILE
ALPINE
131
PLAINFIELD
KNAPP
96
EAST BELTLINE
LEONARD
Allendale
COVELL
196
LAKE MICHIGAN
BRIDGE
MICHIGAN
FULTON
M-21
ROBINSON
CASCADE
COLLEGE
WEALTHY
GRAND RIVER
GRANDVILLE
OTTAWA
FULLER
REEDS LAKE
LAKE DR.
FOREST HILLS
ARGO
HALL
MEDICAL PARK
PARK EAST CT
PLYMOUTH
BURTON RD
DIVISION
EASTERN
BRETON RD
28TH ST
M-11
CHICAGO DR
36TH ST
CANAL
BROADMOOR
PATTERSON
EAST PARIS
To Lansing
44TH ST
AIRPORT
KALAMAZOO
WILSON
54TH ST
52ND ST
60TH ST
M6
68TH ST
Lansing
To Holland
Holland
To Kalamazoo
Kalamazoo

Welcome to Our Practice

Please Print All Information

Today's Date ______________

Robert L. Daniels, M.D. F.A.C.S. Darryl J. Elzinga, M.D.

PERSONAL PHYSICIAN ____________________ Did this physician refer you for a consultation? _______

Physicians Address ____________________ phone ________

Would you like us to send your physician a letter following your consultation? _________ Your e-mail ____________

PATIENT NAME ____________________ Male Female

Last First Middle

Street Address ____________________ Apt.# ________

City ____________ State ______ Zip Code ________ Employer ____________

Home Phone # ____________ Cell Phone # ____________ Work Phone # ____________ ext. ______

Date of Birth ____________ **Social Security# ____________ Marital Status ________

EMERGENCY CONTACT ____________ Relation ________ Phone# ____________

SPOUSE INFORMATION

Name ____________ Date of Birth ____________ SSN ____________

Employer ____________ Phone# ____________

PARENT INFORMATION IF PATIENT IS MINOR

Mother ____________ DOB ________ Father ____________ DOB ________

Address ____________ Address ____________

Employer ____________ SSN ________ Employer ____________ SSN ________

Home # ______ Work ______ Cell ______ Home # ______ Work ______ Cell ______

Parent or legal guardian bringing child to visit is responsible for bill. Name/Relationship ____________

INSURANCE INFORMATION

PLEASE CHECK: ☐ Health Ins. ☐ Work Comp. ☐ Auto Ins. ☐ Other Accident Date of Accident ________

PRIMARY INSURANCE INFORMATION OFFICE COPAY AMOUNT $________

Name of Insurance Company ____________ ID# ____________

Name of Employer ____________ Phone # ____________

Policy Holder Name ____________ Policy Holder date of birth ____________

SECONDARY INSURANCE INFORMATION

Name of Insurance Company ____________ ID# ____________

Name of Employer ____________ Phone # ____________

Policy Holder Name ____________ Policy Holder date of birth ____________

For the purpose of reporting data to government agencies, please provide the following information:

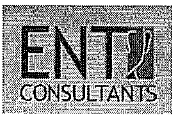
Race: ____White ____Black or African ____American ____Asian ____Native Hawaiian or other Pacific Islander

____ American Indian or Alaskan Native ____Mulitracial

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino

PLEASE PROVIDE US WITH YOUR INSURANCE CARD AND PICTURE ID-THANK YOU

**Your social security number will be protected by ENT Consultants, P.L.C. as required by the Michigan Social Security Number Privacy Act 454 of 2004, MCL 445.81.



_____Darryl J. Elzinga, MD _____Robert L. Daniels, MD

Date____________________Referring Physician______________________________Height________________ Weight_________

Name____Date of birth_________________________Age________

REASON FOR TODAY"S VISIT:

____

____

PAST MEDICAL HISTORY
Do you have any of the following conditions?

High Blood Pressure	yes	no	COPD/Emphysema	yes	no	Thyroid Problems	yes	no
Heart Disease	yes	no	Asthma	yes	no	Stomach Problems	yes	no
Heart Attack	yes	no	Liver Problems	yes	no	Neurologic Problems	yes	no
Diabetes	yes	no	Kidney Problems	yes	no	Cancer type__________		

Other chronic illnesses or past illness/injuries?____

____

CURRENT MEDICATIONS: (please include prescription and over the counter medications and amount of each):

____

____

____

DRUG ALLERGIES (please list drug allergy and reaction):

____

PAST SURGICAL HISTORY-Please list all past surgeries and year:

____

____

ANESTHESIA COMPLICATIONS? YES NO

FAMILY HISTORY Please complete the following regarding your immediate family.
HAS ANY FAMILY MEMBER HAD ANY PROBLEMS WITH THE FOLLOWING:

	Family member (list who)		Family member (list who)
Ear disease	____________	Thyroid disease	____________
Hearing loss	____________	Allergies	____________
Cancer	____________	Musculoskeletal disease	____________
High Blood Pressure	____________	Bleeding	____________
Heart Disease	____________	Hematologic/lymphatic	____________
Stroke	____________	Neurological disease	____________
Anesthesia problems	____________	Diabetes	____________
Other:	____________		

OVER->

PERSONAL HISTORY:

Are you presently working? _______ Occupation:____

Marital Status ☐Single ☐Married ☐Divorced/Separated ☐Widowed

Do you drink alcohol? _____ Amount consumed per WEEK: ________ Do you drink caffeine? _____Amount consumed per DAY: ________

Have you ever used tobacco? ☐Yes ☐No, not currently ☐Never

started (year): _______ quit (year): _______

how many/how much per day? ______________________________

Do you currently or have you ever used illicit drugs (marijuana, cocaine, meth)? _____

REVIEW OF SYSTEMS Please circle yes or no if you are experiencing any of these problems:

CONSTITUTIONAL			CARDIOVASCULAR			ENDROCINE			RESPIRATORY		
Fever/Chills	yes	no	Chest pain	yes	no	Increased Appetite	yes	no	Wheeze	yes	no
Weight loss/Gain	yes	no	Irregular Pulse	yes	no	Decreased Appetite	yes	no	Cough	yes	no
Excessive Fatigue	yes	no	Tightness in chest	yes	no	Excessive thirst	yes	no	Coughing Blood	yes	no
Night sweats	yes	no	Swelling in Feet/Hands	yes	no	Hormone Problems	yes	no	Shortness of Breath	yes	no
EARS			NOSE			THROAT			MUSCULOSKELETAL		
Drainage from Ears	yes	no	Nosebleeds	yes	no	Sore Throats	yes	no	Joint Pain or Swelling	yes	no
Hearing loss	yes	no	Nasal Congestion	yes	no	Hoarseness	yes	no	Arm or leg weakness	yes	no
Ear Pain	yes	no	Nasal Drainage	yes	no	Difficulty swallowing	yes	no	Back Pain	yes	no
Ringing in Ears	yes	no	Sinus Headaches	yes	no	Mouth Sores	yes	no	Muscle Aches	yes	no
GASTROINTESTINAL			EYES			NEUROLOGICAL			HEMATOLOGIC/LYMPHATIC		
Indigestion	yes	no	Glaucoma	yes	no	Seizures	yes	no	Bleeding tendencies	yes	no
Nausea/Vomiting	yes	no	Cataracts	yes	no	Memory Problems	yes	no	Persistent swollen glands	yes	no
Diarrhea	yes	no	Double/Blurred Vision	yes	no	Speech Problems	yes	no	Night Sweats	yes	no
Constipation	yes	no	Vision Change	yes	no	Headache	yes	no	Easy Bruising	yes	no
Abdominal Pain	yes	no	Watery/Itchy Eyes	yes	no	Facial weakness	yes	no	Anemia	yes	no
PSYCHIATRIC			GENITOURINARY			INTEGUMENTARY			ALLERGIC/IMMUNOLOGIC		
Anxiety	yes	no	Difficulty Urinating	yes	no	Skin Rash	yes	no	Food Allergies	yes	no
Depression	yes	no	Painful Urination	yes	no	Sores	yes	no	Nasal Allergies	yes	no
Insomnia	yes	no	Blood in Urine	yes	no	Skin cancer	yes	no	Autoimmune Disease	yes	no

Other: ____________________

The information provided in this form is accurate to the best of my knowledge.

____

Patient Signature Date

____

Parent signature if patient is minor Date

I HAVE REVIEWED THE INFORMATION WITH PATIENT OR PARENT

____

Physician Date

ENT CONSULTANTS, P.L.C.

Patient: ______________________________________ Date of Birth: ______________________

PRIVACY NOTICE

I acknowledge that I have been offered Notice of Privacy Practices for my review.

____ ______________________

Patient or Personal Representative Signature Date

OFFICE NOTE: ____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Individual Name: ____

Person/entity authorized to provide the information: ENT CONSULTANTS, PLC

Person/entity authorized to receive the information: ____

____

Specific description of information (including dates): ______________________________________

The purpose of the use or disclosure is: ____

Will the person or entity requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

Yes _____ No _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials** _____

I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. **Initials** _____

I understand that this authorization will expire on _______________

I understand that I may revoke this authorization at any time by written notice to ENT Consultants. I also understand that if I revoke this authorization, the revocation will not have any effect on actions taken by ENT Consultants before ENT Consultants received the revocation. I also understand that more information regarding revocation of this authorization may be covered in ENT Consultants's Notice of Privacy Practices.

____ ______________________

Patient or Personal Representative Signature Date

FINANCIAL POLICY OF ENT CONSULTANTS, PLC

We are dedicated to providing the best possible care for you and your family, accordingly, we want you to completely understand our financial policies and your financial responsibilities.

1. We have made prior arrangements with many insurance companies to accept an assignment of benefits. We will bill them on your behalf and **you are required to pay your copayment at the time of service.** We accept cash, personal checks, Visa and MasterCard.

2. If you are insured by a plan we do not have a prior arrangement with, we will submit the claim as a courtesy, but you will be responsible for payment of the charges at the time of service.

3. Keep in mind that your insurance policy is a contract between you and your insurance carrier. As a service to you, we will file your insurance claim if you assign benefits to the doctor – in other words, if you agree to have your insurance carrier pay us directly. If your insurance company does not pay within 90 days, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

4. Not all insurance plans cover all services. If your insurance determines a service to be "not covered", you will be responsible for the total charge. Payment for these services is due upon receipt of a statement from our office.

5. An administration fee will be assessed to any account that is delinquent unless prior arrangements have been made. Accounts are considered delinquent after two statements have been mailed to the patient's home address.

6. As a courtesy, we try to confirm appointments the day before they are scheduled. However, a fee may be assessed for missed appointments that are not cancelled or rescheduled before the appointment time.

7. Due to the Federal Bankruptcy laws it is the policy and practice of this office to discharge patients and their families who have debt with us if bankruptcy is filed. However, these cases will be addressed on an individual basis. This policy was put into place due to the financial hardship bankruptcy cases cause the practice. If you have bankruptcy concerns or questions, please ask to speak to the billing department.

8. Self pay patients may be asked to provide a deposit equal to a minor office visit on the date of service for non-emergent care. **Any self pay balances are required to be paid in full within 30 days of the date of service.**

I have read and understand the practice's financial policy and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party) Date

Printed name of patient Date

Revised 07/09