AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094

Ear/Otitis Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: _____ ID/SSN: _____

Form No._____

Name of person treated: _____ Relationship to applicant: _____

1. Have you ever been diagnosed with any of the following disorders? Please check all that apply.
   ☐ Otitis (ear infection) ☐ Hearing loss ☐ Vertigo (dizziness) ☐ Cholesteatoma/otoslerosis ☐ Other (labyrinthitis)

2. Date diagnosed or date of first symptoms:_____
   Number of episodes in the last year: _____

3. Have you ever been seen by an ENT (ears, nose, throat specialist)? ☐ Yes ☐ No

4. Have you ever had a hearing test or tympanogram? ☐ Yes ☐ No
   If yes, when and what were the results? _____
   _____

5. Has there been any treatment in the past, such as tube placement, etc? ☐ Yes ☐ No If yes, please give details of _____ treatment:_____
   _____
   _____

6. Is there any current treatment: ☐ Yes ☐ No If yes, please give details of treatment: _____
   _____
   _____

7. Is there any prescription medication taken for this condition? ☐ Yes ☐ No If yes, please list:
   Name of medication Amount taken per day How often per day
   _____
   _____
   _____

8. Name and address of treating physician: _____
   _____

9. Date last seen for this condition:_____

10. Have you ever had or been advised to have surgery regarding this condition? ☐ Yes ☐ No If yes, please explain: _____
    _____
    _____
    _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

_____ _____
Signature of person treated (or parent/guardian if under 18) Date