HEAD & NECK ASSOCIATES OF ORANGE COUNTY, INC.

| Balaker | Bredenkamp | Buen | Cho | Crockett | Feinberg | Jakobsen | Luu |
| Mundi | Thompson | Wells |

PATIENT INFORMATION

NAME: _____ _____ _____ _____ BIRTH SEX: M ☐ F ☐
Last First MI Nickname

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

BIRTHDATE: _____ /_____ /_____ SS#: _____ - _____ - _____ MARITAL STATUS: S ☐ M ☐ D ☐ W ☐ O ☐

PREFERRED CONTACT
PHONE NUMBERS: 1. (_____) _____ Phone type: _____ 2. (_____) _____ Phone type: _____

E- MAIL ADDRESS: _____ PRIMARY LANGUAGE: _____

RACE: ☐AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ASIAN ETHNICITY: ☐HISPANIC/LATINO ☐ OTHER
☐CAUCASIAN ☐PACIFIC ISLANDER ☐ OTHER _____ ☐NON-HISPANIC/LATINO

REFERRING PHYSICIAN: _____ _____OFFICE NUMBER: (_____) _____
Last First OFFICE LOCATION:_____

EMERGENCY CONTACT: _____ PHONE: (_____) _____ RELATIONSHIP: _____

Please print the name and relationship of the persons you authorize to receive protected health care information:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

INSURANCE POLICY INFORMATION

POLICY HOLDER'S NAME: _____
Last First MI

BIRTHDATE: _____ /_____ /_____ SS#: _____ - _____ - _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

PRIMARY INSURANCE CO: _____ POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S BIRTHDATE: _____ /_____ /_____

POLICY #: _____ GROUP #: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CO: _____ POLICY HOLDER'S EMPLOYER: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S BIRTHDATE: _____ /_____ /_____

POLICY #: _____ GROUP #: _____ RELATIONSHIP TO PATIENT: _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I assign and request payment of medical benefits be made to **HEAD AND NECK ASSOCIATES OF ORANGE COUNTY, INC**. for medical services rendered. I authorize the release of medical information necessary to process my claim. I also authorize that I may be contacted via any of the above contact information I have provided. **I have read the Financial Policies and understand that I am financially responsible for any non-covered services.**

_____ _____ /_____ /_____
Patient Signature **Date**

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FINANCIAL POLICIES

Head and Neck Associates will submit claims to your insurance company for all medical services rendered. We will attempt to verify eligibility and benefits with your insurance company; however, this verification is not a guarantee of payment. Any expenses deemed not covered by your insurance company will be your financial responsibility.

All monies owed by the patient, i.e., office visit copayments and non-covered services or supplies are due at the time of service. Also, when applicable, coinsurance percentages and/or deductibles may be collected at the time of service. Please be aware that this office will bill only for the physicians' services. Any other services related to your office visits, i.e., laboratory, radiology or pathology will be billed by the facility providing these services.

In order to properly evaluate our patients, it is often necessary for the physician to perform an in-office procedure such as, but not limited to:

fiberoptic laryngoscopy	***ultrasounds***	***hearing tests***
biopsies	***fiberoptic nasal endoscopy***	***CT scans***

These services are billed as an additional charge from the office visit and additional coinsurance and/or deductible amounts may apply. Although these services are done in the office, they are often labeled as "surgery" on your insurance company explanation of benefits. If you have any questions regarding the necessity of any of these services, please direct them to your physician at the time of service.

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND THE ABOVE: _____

It is your responsibility to provide Head and Neck Associates with proof of insurance and an authorization number or referral when applicable. If these items are not provided we ask that you pay in full at the time of service.

The contract between Head and Neck Associates and your health plan, as well as the contract between you and your health plan requires that you make payment in full of all co-payments and deductible amounts deemed to be your responsibility upon claims processing. Additional discounts are forbidden by contract unless financial hardship is documented in writing by the patient.

Our office accepts the following forms of payment: most major credit cards, cash, and personal checks. A $20 service charge will be assessed to your account for any check returned by your bank.

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the **Notice of Privacy Practices** being adhered to by Head and Neck Associates of Orange County. The Notice of Privacy Practices is supplied in accordance with the Privacy rule that is an integral part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

A physical copy of the HIPAA Acknowledgement can be provided upon request.

_____	_____	_____
Printed Patient Name	**Patient Birthdate**	**Date Signed**
_____	_____	
Signature of Patient (Parent if Patient is Minor)	**Relationship to Patient** (If Patient is Minor)	

Head and Neck Associates of Orange County, Inc.

Patient we are required by the State of California to provide you with this notice of the Open Payments Database.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

_____

Print Patient Name (or Guardian)

_____

Signature

_____

Date

www.hnaoc.com
26726 Crown Valley Parkway, Suite 200 • Mission Viejo, CA 92691 • 949-364-4361 • Fax 949-364-4495

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Date: _____

Name: _____ *Date of Birth:* _____

Primary Care Physician: _____ *Pharmacy:* _____

Doctor who referred you (first and last name): _____ *Office Phone:* _____

Other physicians caring for you: _____ Height: _____ Weight: _____

Reason for Visit: _____ Date of Injury: _____

- Have you had an Influenza Vaccination (Flu Shot)? ☐ YES ☐ NO

  If yes, please indicate: Date performed _____ Performed by _____

- *65 years or above, have you received the Pneumococcal Vaccine (Pneumovax Injection)? ☐ YES ☐ NO

  If yes, please indicate: Date performed _____ Performed by _____

Medications: Please list medications and dosages ☐ **NO** medications

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies: Please list allergies to medications ☐ **NO** allergies to medications

1. _____ Reaction: _____
2. _____ Reaction: _____

Please **SELECT** symptoms that apply to why you are being seen by us today:

Constitutional:
☐Abnormal weight change
☐Fever
☐Chills
☐Fatigue

Respiratory:
☐Cough
☐Snoring
☐Wheezing
☐Shortness of breath

Cardiovascular:
☐Chest Pain
☐Palpitations

Gastrointestinal:
☐Abdominal Pain
☐Constipation
☐Diarrhea
☐Vomiting

Neurological:
☐Trouble walking
☐Non-restorative sleep
☐Fainting
☐Tingling

Psychological:
☐Increased anxiety
☐Depression
☐Behavior changes

Ear/Nose/Throat:
☐Hearing Loss
☐Ear Pain
☐Hearing noises in ear
☐Dizziness
☐Trouble swallowing
☐Change in Voice
☐Throat Pain
☐Post-nasal drip
☐Nasal Congestion
☐Headache
☐Jaw pain

Musculoskeletal:
☐Neck stiffness
☐Increased muscle pain
☐Increased joint pain
☐Muscle weakness

Genitourinary:
☐Change in urinary color
☐Increased urgency
☐Blood in urine
☐Pain when urinating

Allergy/Immunology:
☐Hay fever
☐Hives
☐Food allergies

Completed by ☐ Patient or _____ Relationship _____

Head and Neck Associates of Orange County, Inc.

Date: _____

Name: _____ *Date of Birth:* _____

Past Medical History: Please **SELECT** if you have been diagnosed or had any of the following:

☐ Anesthesia complications
☐ Anxiety
☐ Asthma
☐ Bleeding Disorders
☐ Congestive Heart Failure
☐ Cancer: Type _____
☐ Diabetes: Type _____
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Headaches, Migraines
☐ Heart Attack
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Irregular Heartbeat
☐ Immune Suppression
☐ Kidney Disorders
☐ Reflux (GERD)
☐ Sleep Apnea
☐ Stroke

Please list any other medical conditions: _____

Past surgeries with approximate dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family History:

	Alive?	**Age/Age of Death**	**Cardiac Issues?**	**Cancer? What Kind?**	**Anesthetic reaction?**	**Other:**
Mother:	☐Yes☐No		☐Yes☐No	☐Yes☐No	☐Yes☐No	
Father:	☐Yes☐No		☐Yes☐No	☐Yes☐No	☐Yes☐No	

Social History:

Have you ever used tobacco products? ☐ YES ☐ NO

If so, please **SELECT** which apply: ☐ **Cigars** ☐ **Cigarettes** ☐ **E-cigarettes** ☐ **Hookah** ☐ **Chew** ☐ **Vape**

How much per day? _____ How many years? _____ Age stopped: _____

Do you drink alcohol? ☐ YES ☐ NO How many drinks per day? _____

Please **SELECT** which drugs you have used: ☐ **Cocaine** ☐ **Ecstasy** ☐ **Heroin** ☐ **LSD** ☐ **Marijuana** ☐ **Other**_____

Describe your exercise level: ☐ **Sedentary** ☐ **Moderate** ☐ **Vigorous**

What type of exercise? _____

Completed by ☐ Patient or _____ Relationship _____