THINGS TO BRING TO YOUR VISIT WITH THE DOCTOR

Please check each item to ensure you've brought everything.

☐ Current insurance card (s).

☐ Correct co-payment amount. Credit card (MC or Visa) or check, payable to Head & Neck Associates.

☐ New patient packet, if mailed to you in advance. Arrive 30 minutes early if you did not receive a new patient packet. You may also obtain it at www.hnaoc.com. Click on new patient tab.

☐ Parent/Legal guardian, if a minor.

☐ CT, MRI & all other diagnostic films (x-ray films or CDs) and reports.

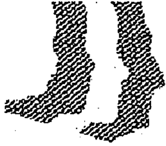
It is your responsibility to ensure that you bring the films and reports. Failure to do so will delay your visit or require an additional visit to our office. Don't just bring the report.

☐ Copies of any diagnostic tests done by another doctor (i.e. sleep study, biopsy).

☐ Name, address and telephone number of the physicians treating you. Include the doctor who referred you to our practice

☐ List of all medications & dose your currently taking.

Any questions, please contact our office at (949) 364-4361



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Dennis M. Crockett, M.D., F.A.C.S.
Diplomates, American Board of Otolaryngology
Head & Neck Surgery Pediatric & Adult Otolaryngology Facial Reconstructive Surgery

Welcome to *Head and neck Associates of Orange County, Inc*
We are delighted that you have chosen our practice for your medical care!
We are located at:
675 Camino de los Mares Suite 420
San Clemente California 92673

Our office is located on the corner of Camino de los Mares and Marbella. There is parking in front of the building on either side. Take the elevator to the 4th floor and go down the hall to your right.

At this time, we would like to confirm your appointment with:
Dr. ____________________, scheduled at ______: __________AM/PM
On:________________ ______/____/____

It is the policy of our office to insist that a parent or legal guardian accompany their minor child. The physician may choose to reschedule your child's appointment if he/she is not accompanied by a parent or legal guardian .On the day of your appointment, please arrive at out office 30 minutes prior to your scheduled visit time. This allows extra time to complete any additional information needed.

We have enclosed a new patient information sheet, a copy of our financial policies, a medical questionnaire, an arbitration agreement and a map to help locate the office. Please fill out each section of the information sheet completely. **This office mandates the use of arbitration agreements. An arbitration agreement will be presented to you at the time of your initial visit.**

Bring your completed forms, along with your current insurance card, and any x-ray/CT films (with reports) to your appointment. **Please do not mail these forms back to our office.** In order to assist you with collecting your maximum insurance benefits, we may ask for a copy of your insurance card at each visit. Co-payments will be collected at the time of sign in. Some insurance companies require prior authorizations / referrals for any visit. Please refer to your health care manual to find out if this applies to you. Usually, a prior authorization number is obtained through your primary care physician or insurance company.

Thank you for taking time to read this letter and complete the required forms. We look forward to seeing you!

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24411 Health Center Drive, Suite 370 • Laguna Hills, CA 92653 • 949-581-3888 • Fax 949-581-3883
675 Camino de los Mares, Suite 420 •San Clemente, CA 92673 • 949-496-2307 • Fax 949-496-8688

Address

675 Camino de Los Mares #420
San Clemente, CA 92673

Coming from Mission Viejo

- 5 freeway South
- Exit Camino de Estrella
- Turn LT at light onto Camino de los Mares
- Turn LT & U-turn at Marbella
- Building on RT
- Parking in front of building
- Forth floor, suite 420 down the hall to your right

Going North from San Diego area

- 5 Freeway North
- Exit Camino de Estrella
- Turn RT onto Camino de los Mares
- Turn LT & U-turn at Marbella
- Building on RT
- Parking in front of building
- Forth floor suite 420 down the hall to your right

HEAD & NECK ASSOCIATES OF ORANGE COUNTY, INC.

(Please Print)

BREDENKAMP / CHO / CROCKETT / JAKOBSEN / SUPANCE / WOHLGEMUTH / WELLS ACCT #____________

PATIENT INFORMATION

NAME: ____
Last First MI Nickname

ADDRESS: ____
Street City State Zip Code

HOME PHONE: (___) ____________________ WORK OR CELL PHONE: (___) ____________________

BIRTHDATE: ____/____/____ EMPLOYER NAME: ____________________

PRIMARY CARE / REFERRING PHYSICIAN NAME: ____________________

SS#: _______/_______/________ MARITAL STATUS: S ____ M ____ D ____ W ____ O _____

SEX: M ____ F ____ E-MAIL Address: ____________________

EMERGENCY CONTACT: ____________________ PHONE: (___)____________________

SPOUSE AND / OR OTHER INSUREDS INFORMATION

NAME: ____
Last First MI Nickname

ADDRESS (IF DIFFERENT): ____
Street City State Zip Code

BIRTHDATE: ____/____/____ SS#: ______/______/______ RELATIONSHIP TO PT: ______________

INSURANCE POLICY INFORMATION

PRIMARY INSURANCE CO:____________________ Relationship to Patient: _______

INSURED'S NAME:____________________ INSURED'S DATE of BIRTH: ___/___/___

ID #: ____________________ GROUP #: ________ INSURED'S EMPLOYER: ______________

SECONDARY INSURANCE CO: ____________________ Relationship to Patient: ________

INSURED'S NAME:____________________ INSURED'S DATE OF BIRTH: ___/___/___

ID#: ____________________ GROUP #: _________ INSURED'S EMPLOYER: ______________

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

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

______________________________________ ____________________

Patient Signature **Date**

John S. Supance, M.D., F.A.C.S. • Mark A. Wohlgemuth, M.D., F.A.C.S. • James K. Bredenkamp, M.D., F.A.C.S.
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PATIENT CONTACT PREFERENCE

In accordance with the Health Insurance and Portability Act (HIPAA), we are required to institute specific confidentiality safeguards regarding your medical health information. It will be necessary for our office staff to contact you regarding scheduled appointments, possible surgery scheduling, lab diagnostic test results and other related matters such as insurance coverage and billing.

Many people have multiple communication devices such as cell phones, work or home voice mail / answering machine systems. Consequently, we require specific instructions as to how best to contact you. In addition, if you wish other members of your household or other designated persons to be authorized to receive this protected health information, you must indicate those individuals that are authorized to be made aware of such information.

Please rank in order of preference all phone numbers at which we may contact you to leave information about your appointment, surgical time or other related health information:

☐ Home Telephone: (___) ________________ 1 2 3 (Circle)

☐ Cell Phone: (___) ________________ 1 2 3 (Circle)

☐ Work Telephone: (___) ________________ Ext: _______ 1 2 3 (Circle)

If you are not available, may we leave information or instructions with a family member or other authorized person? ☐ Yes ☐ No

Please PRINT the names and relationships of persons authorized to receive protected health information:

______________________________ ______________________
Name Relationship

______________________________ ______________________
Name Relationship

May we also contact you via e-mail? Y / N If yes, email address: ____________________

______________________________ ______________________
Signature of Patient, Parent or Guardian Print Name of Patient

____
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 guaranty 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   ***biopsies***   ***ultrasounds***
fiberoptic nasal endoscopy   ***hearing testing***   ***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.

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 twenty-dollar service charged will be assessed to your account for any check returned by your bank.

________________________   ________________
Responsible party signature   Date

____
Patient name (Please Print)

Date:___________

HEAD AND NECK ASSOCIATES OF ORANGE COUNTY

ADULT MEDICAL QUESTIONNAIRE

Name:_________________________ Age:_____ Date of birth:_______________
Primary Care Doctor:____
Doctor who referred you:____
Other physicians caring for you:_____________________________________

Are your symptoms a work related injury: **Yes/no** Date of injury:_______________
Are you pregnant? **Yes/no**

Reason for Visit: ____
****

- **PAST MEDICAL HISTORY**
  (Have you been diagnosed with or treated for any of the following diseases?)

Angina or Heart Attack	**Yes/no**	Glaucoma/Cataracts	**Yes/no**
Anesthesia complications	**Yes/no**	Headaches	**Yes/no**
Asthma	**Yes/no**	High Blood Pressure	**Yes/no**
Bladder disease	**Yes/no**	Immune suppression/ HIV	**Yes/no**
Bleeding Problems	**Yes/no**	Irregular Heart Beat	**Yes/no**
Blood Transfusions	**Yes/no**	Liver problems/Hepatitis	**Yes/no**
Congestive Heart Failure	**Yes/no**	Sleep Apnea	**Yes/no**
Cancer	**Yes/no**	Snoring	**Yes/no**
Diabetes Mellitus	**Yes/no**	Stroke	**Yes/no**
Emphysema	**Yes/no**	Thyroid disease	**Yes/no**
Epilepsy	**Yes/no**	Ulcers or Reflux (GERD)	**Yes/no**

SURGERIES AND HOSPITALIZATIONS

List all previous surgeries/hospitalizations, and approximate dates:

1.______________________________
2.______________________________
4.______________________________
5.______________________________

CURRENT MEDICATIONS WITH DOSAGES

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
6.______________________________

Do you take any "blood thinners? **Yes/no**
Do you take aspirin containing medications? **Yes/no**

ALLERGIES TO DRUGS
YES (list if YES) / **NO**
1.____________________
2.____________________
3.____________________

ENVIRONMENTAL ALLERGIES
YES (list if YES) / **NO**
1.____________________
2.____________________
3.____________________

- **REVIEW OF SYSTEMS – PAST 30 DAYS**

(Circle **Yes** or **No.** If **Yes,** put a Check next to any illnesses, problems, or symptoms you have had in the past 30 days)

Yes/No: EYES
- ☐ Change in Vision
- ☐ Pain
- ☐ Blurred or double vision
- ☐ Glaucoma

Yes/No: CONSTITUTIONAL SYMPTOMS
- ☐ Fevers, Chills, or Night sweats
- ☐ Recent Weight change
- ☐ Skin problems

Yes/No: RESPIRATORY
- ☐ Cough
- ☐ Spitting up blood
- ☐ Wheezing

Yes/No: MUSCULOSKELETAL
- ☐ Joint pain/stiffness
- ☐ Muscle pain/cramps/weakness
- ☐ Back pain

Yes/ No: GENITORUINARY
- ☐ Flank pain
- ☐ Problems with urination
- ☐ Abnormal urine color

Yes/ No: CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath, walking or lying flat
- ☐ Swelling of feet, ankles or hands

Yes/ No: EARS/NOSE/MOUTH/THROAT
- ☐ Hearing loss
- ☐ Hearing noises in your ear(s)
- ☐ Earaches or drainage
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ Sinusitis
- ☐ Sore throat
- ☐ Snoring
- ☐ Voice changes
- ☐ Oral bleeding
- ☐ Difficulty and or pain with swallowing

Yes/ No: GASTROINTESTINAL
- ☐ Problems with bowel movements
- ☐ Nausea or vomiting
- ☐ Rectal bleeding, blood in stool, vomiting blood
- ☐ Abdominal pain or heartburn

Yes/ No: HEMATOLOGIC/LYMPHATIC
- ☐ Slow to heal after cut
- ☐ Bleeding or bruising tendency

Yes/ No: NEUROLOGICAL
- ☐ Headaches
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Head injury
- ☐ Fainting or loss of consciousness

Yes/No: OTHER SYMPTOMS
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

- **FAMILY HEALTH HISTORY**

	Father	Mother
Alive	Yes/No	Yes/No
Age or Age at death	______	______
Angina or Heart Attack	Yes/No	Yes/No
Diabetes Mellitus	Yes/No	Yes/No
Congestive Heart Failure	Yes/No	Yes/No
High Blood Pressure	Yes/No	Yes/No
Adverse Anesthetic Reactions	Yes/No	Yes/No
Liver Problems/Hepatitis	Yes/No	Yes/No
Bleeding Disorders	Yes/No	Yes/No

HABITS

Do you now smoke? (circle cigars/cigarettes) **Yes No**

How many years____ Packs per day?____

Have you ever smoked? **Yes No**

How long ago?_____ For how many years?______

How many packs per day (average)? ______

Have you ever used chew or snuff? **Yes No**

Do you drink alcohol? **Yes No**

How many drinks per day (average)? ___

When did you last drink? _____

Have you used illicit drugs (including marijuana, heroin, cocaine, LSD, crack)? **Yes No**

If yes, circle which ones.

Do you exercise on a regular basis? **Yes No**

Type of exercise?_____ How often?___

****

Besides the information that will be entered in the following pages, is there anything else or other information that you would like us to know? ________________________________

____

____

Reviewed by MA ______________________

Reviewed by MD ______________________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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).

Notify our office staff if you wish to retain a copy of the Notice of Privacy Practices.

____________________________ ____________________
Signature   Date

____________________________ ____________________
Patient Name   Relationship to Patient

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you as a patient of Head and Neck Associates may be used and disclosed, your rights as a patient and how you can access your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Head and Neck Associates is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information as prescribed by HIPAA. These HIPAA guidelines are summarized below for your information and understanding.

Use and Disclosure of your Health Information

The following circumstances may require Head and Neck Associates to use or disclose your health information.

1. To comply with requests from public health authorities and health oversight agencies which are required by law to collect health information.
2. Law suits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Head and Neck Associates will only make such disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces, including veterans, and if required by the appropriate authorities.
6. To federal government officials for intelligence and national security activities required by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

Your Rights regarding your Health Information

1. You can request that Head and Neck Associates communicate with you about your health related issues in a particular manner or at a certain location. Therefore, you may ask to be contacted at home rather than work, via personal fax or cell telephone for appointment confirmations or related scheduling matters, for results of specific diagnostic tests, and such reasonable requests will be accommodated.
2. You can request a restriction regarding the use or disclosure of your health information for treatment, payment, or health care operations by Head and Neck Associates.
3. You have the right to request that Head and Neck Associates restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as a family member or friend. However, Head and Neck Associates is not required to agree to your requests, but if we do agree, Head and Neck Associates is bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical and billing records, **with the exception of psychotherapy notes.** You must submit your request in writing to Head and Neck Associates, Attn: Beth Page, HIPAA Privacy Officer, at 26726 Crown Valley Pkwy., Suite 200, Mission Viejo, CA 92691. Obtain a request form from one of the Front Desk receptionists.
5. You may ask Head and Neck Associates to amend your health information if you believe it is incorrect or incomplete as long as the information is kept by or for Head and Neck Associates. To request an amendment, make your request in writing with a supporting reason for the amendment to your health information to Head and Neck Associates, Attn: Beth Page, HIPAA Privacy Officer, at 26726 Crown Valley Pkwy., Suite 200, Mission Viejo, CA 92691. Obtain a request form from one of the Front Desk receptionists.
6. You are entitled to receive a copy of the Notice of Privacy Practices by asking the Front Desk receptionist to make you a photocopy.
7. If you believe your privacy rights have been violated, you may file a complaint with Head and Neck Associates or with the Secretary of the Department of Health and Human Services. Any complaint filed with Head and Neck Associates must be submitted in writing. You will not be penalized for filing a complaint. Obtain the proper form to file a complaint from one of our Front Desk receptionists or Medical Assistants.
8. Head and Neck Associates will obtain your written authorization for uses and disclosures that are not identified by this Notice of Privacy Practices or permitted by law.

If you have any questions regarding this Notice of Privacy Practices or Head and Neck Associates' health information privacy policies, please contact Beth Page, HIPAA Privacy Officer at Head and Neck Associates, 26726 Crown Valley Pkwy., Suite 200, Mission Viejo, CA 92691.

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Assignment of Benefits and Release of Information to Medicare

I request the payment of authorized Medicare benefits be made either to me or on my behalf to the physicians(s) or supplier listed below for any services provided to me by that physician or supplier. I authorize any holder of medical information about me to release to the **Centers for Medicare and Medicaid Services** and its' agents any information needed to determine benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other insurance coverage is listed on my claim form or electronic claim my signature authorizes the release of information to the insurer shown. **In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services.** Co-insurance and deductible are based upon the charge determination of the Medicare carrier. This assignment is valid from today's date and remains in effect until I, the patient, revoke this agreement.

Head and Neck Associates of Orange County, Inc.
John S. Supance, M.D., Mark A. Wohlgemuth, M.D.,
James K. Bredenkamp, M.D., Michael K. Jakobsen, M.D.,
Michael Cho, M.D., Phillip R. Wells, M.D., Dennis M. Crockett, M.D.

____

Signature of patient **Date**

_______-______-_____-_______

Medicare Number (Required)

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