# 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!

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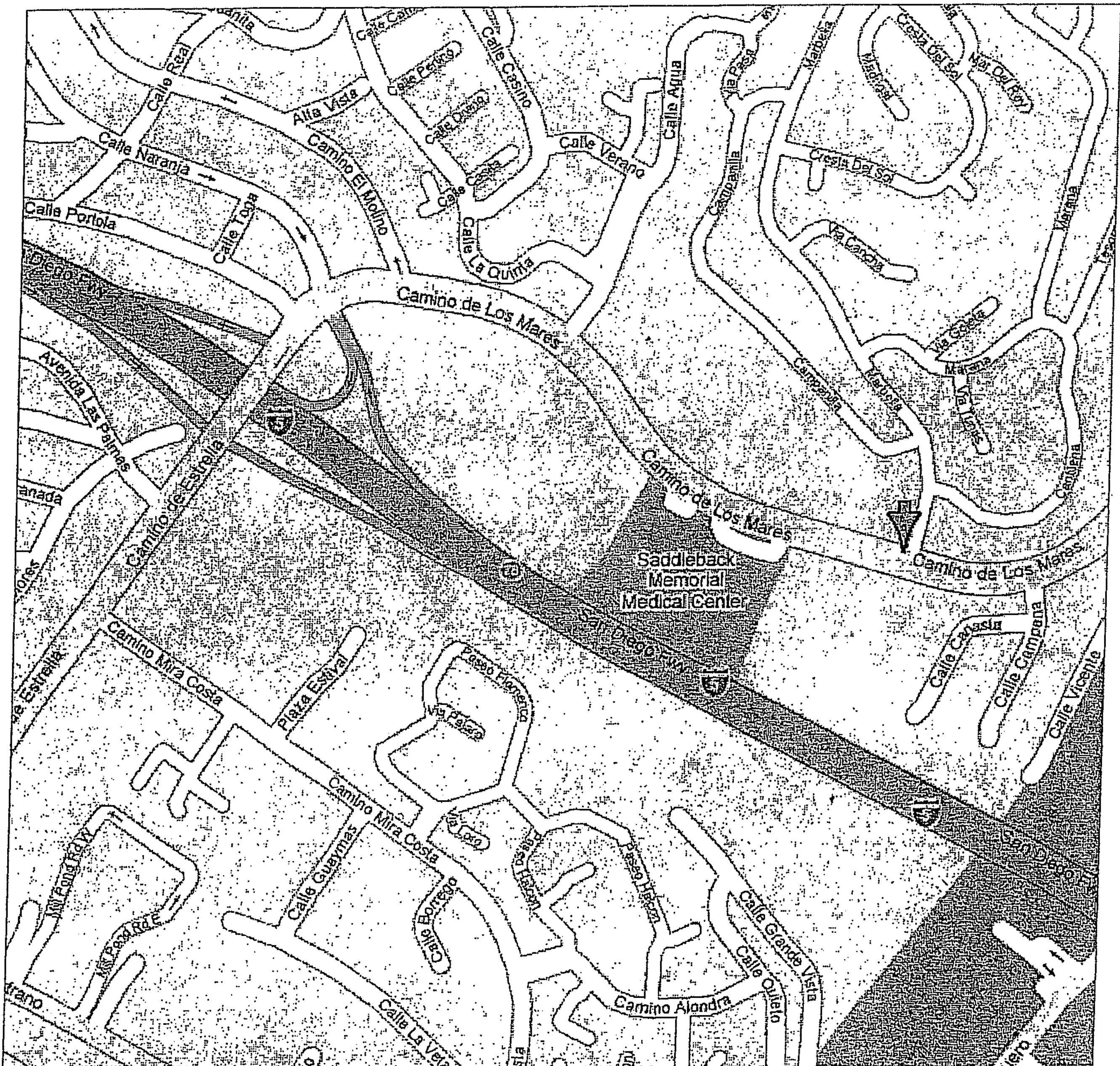
24411 Health Center Drive, Suite 370 • Laguna Hills, CA 92653 • 949-581-3888 • Fax 949-581-3883
675 Camino de los Mares, Suite 420 •San Clemente, CA 92673 • 949-496-2307 • Fax 949-496-8688

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 #______________**

## PARENT AND / OR OTHER INSUREDS INFORMATION

NAME: ___________________________________________________________________ ________________
Last First MI Relationship to Patient

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

BIRTHDATE: _____/_____/_____ SS#: _______/_______/_______ HOME PHONE: (___) __________________

EMPLOYER: ________________________________________ WORK OR CELL PHONE: (___) _______________

PRIMARY LANGUAGE______________________ RACE-(circle)AMERICAN INDIAN- ASIAN – CAUCASIAN
AFRICAN AMERICAN – NATIVE HAWAIIAN
OTHER PACIFIC ISLANDER - UNKNOWN

ETHNICITY (circle) HISPANIC/LATINO – NON HISPANIC/LATINO - UNKNOWN

## PEDIATRIC PATIENT INFORMATION (Newborn thru age 17)

NAME:_________________________________________________________________________________
Last First MI Nickname

ADDRESS: _____________________________________________________________________________
Street City State Zip Code

BIRTHDATE: ____/______/______ M _______ / F _________

PRIMARY CARE / REFERRING PHYSICIAN NAME: __________________________________________

EMERGENCY CONTACT: ________________________________ PHONE: (___) ____________________

## INSURANCE POLICY INFORMATION

**PRIMARY INSURANCE CO**:_________________________________________________________________

INSURED'S NAME: __________________________________ INSURED'S DATE of BIRTH: ___/___/__
(Mother / Father)

ID/SS #: ______________________ GROUP #: _________ INSURED'S EMPLOYER: ________________

**SECONDARY INSURANCE CO**: ____________________________________________________________

INSURED'S NAME: _________________________________ INSURED'S DATE OF BIRTH: ___/___/___
(Mother / Father)

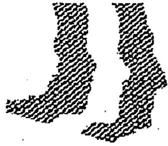
ID/SS#: ______________________ GROUP #: __________ INSURED'S EMPLOYER: ________________

## 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.**

__________________________________________________________ __________________ **02-12rrm**

**Patient Signature** **Date**



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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)

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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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Date:_________

HEAD AND NECK ASSOCIATES OF ORANGE COUNTY

# PEDIATRIC MEDICAL QUESTIONNAIRE

## **Parent fill out on behalf of young pediatric patient**

Name:____________________________ Age:______ Date of birth: ___/___/___Birthplace:_________
Primary Care Doctor:______________________ Date of last Exam:________________
Other physicians caring for your child:_______________________________________________
Current Weight ________ pounds

************************************************************************************

## PAST MEDICAL HISTORY

| | | | |
|---|---|---|---|
| Hypertension: | Yes/no | Ulcers or Reflux (GERD): | Yes/no |
| Irregular Heart Beat: | Yes/no | Asthma: | Yes/no |
| Cardiac Defect: | Yes/no | Pneumonia: | Yes/no |
| Sleep Apnea: | Yes/no | Diabetes: | Yes/no |
| Heart Failure: | Yes/no | Anesthesia Complications: | Yes/no |
| Thyroid Disease: | Yes/no | Family History of Anesthesia Complications: | Yes/no |
| Liver Disease/Hepatitis/Jaundice: | Yes/no | Blood transfusions: | Yes/no |
| Kidney or Urinary Tract Disease: | Yes/no | Bleeding Problems: | Yes/no |
| Seizures: | Yes/no | Family History of Bleeding Problems: | Yes/no |
| Psychiatric Problems: | Yes/no | Previous history of head trauma: | Yes/no |
| Immune suppression or HIV | Yes/no | Tuberculosis or Herpes | Yes/no |
| Rheumatic Fever/Scarlet Fever | Yes/no | Measles or German Measles | Yes/no |
| Chicken Pox | Yes/no | Polio | Yes/no |

## SURGERIES

List all previous surgeries with approximate dates:

1.____________________________ 4.____________________________
2.____________________________ 5.____________________________
3.____________________________ 6.____________________________

## HOSPITALIZATIONS and COMPLICATIONS

List all previous hospitalizations and/or complications with approximate dates:

1.____________________________ 4.____________________________
2.____________________________ 5.____________________________
3.____________________________ 6.____________________________

## CURRENT MEDICATIONS

List all medications with dosages:

1.____________________________ 4.____________________________
2.____________________________ 5.____________________________
3.____________________________ 6.____________________________

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

## ALLERGIES

List all drug allergies:

1.____________________________
2.____________________________
3.____________________________

List all environmental or food allergies:

1.____________________________
2.____________________________
3.____________________________

- BIRTH HISTORY

Was the pregnancy normal? Yes/no Full Term or Premature

Type of delivery: Vaginal C-section Forceps

- HEALTH HISTORY/REVIEW OF SYSTEMS

**( Place a check mark next to any illnesses, problems, or symptoms your child has had in the past month?)**

**CONSTITUTIONAL SYMPTOMS**
- ☐ Good general health
- ☐ Recent Weight change
- ☐ Loss of appetite
- ☐ Fatigue

**EYES**
- ☐ Eye disease or injury
- ☐ Wear glasses or contact lenses
- ☐ Blurred or double vision
- ☐ Glaucoma

**EARS/NOSE/MOUTH/THROAT**
- ☐ Hearing loss
- ☐ Hearing noises in your ear(s)
- ☐ Earaches or drainage
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Snoring
- ☐ Voice changes

**MUSCULOSKELETAL**
- ☐ Joint pain/stiffness
- ☐ Muscle pain/cramps/weakness
- ☐ Back pain

**CARDIOVASCULAR**
- ☐ Chest pain or angina pectoris
- ☐ Palpitations
- ☐ Shortness of breath, walking or lying flat
- ☐ Swelling of feet, ankles or hands
- ☐ Murmur

**RESPIRATORY**
- ☐ Cough
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

**GASTROINTESTINAL**
- ☐ Problems with bowl movements
- ☐ Nausea or vomiting
- ☐ Rectal bleeding or blood in stool
- ☐ Abdominal pain or heartburn

**GENITORUINARY**
- ☐ Flank pain
- ☐ Problems with urination
- ☐ Abdominal urine
- ☐ Kidney stone

**NEUROLOGICAL**
- ☐ Headaches
- ☐ Numbness or tingling sensations
- ☐ Tremors
- ☐ Head injury

**HEMATOLOGIC/LYMPHATIC**
- ☐ Slow to heal after cut
- ☐ Bleeding or bruising tendency
- ☐ Phlebitis/blood clots
- ☐ Past blood transfusion

**OTHER SYMPTOMS**
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

**************************************************************************************

- PLEASE DESCRIBE YOUR SYMPTOMS OF YOUR **PRESENT** PROBLEM:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**************************************************************************************

- **ANSWER THE FOLLOWING QUESTIONS IF YOUR SYMPTOM IS EAR RELATED.**

| | | | | |
|---|---|---|---|---|
| Do you have hearing loss? | Yes/no | Right | Left | Both |
| Do you have ringing in the ears? | Yes/no | Right | Left | Both |
| Do you have pain in the ears? | Yes/no | Right | Left | Both |
| Do you or have you had drainage from the ears? | Yes/no | Right | Left | Both |
| Do you have ear fullness, plugging, or popping? | Yes/no | Right | Left | Both |
| Do you or have you had frequent or chronic ear infections? | Yes/no | Right | Left | Both |
| How many ear infections during the past year? __________________ | | | | |
| Have you been on "preventative" antibiotics | Yes/no | | | |
| Did you get ear infections while on antibiotics? | Yes/no | | | |
| Do you wear hearing aids? | Yes/no | Right | Left | Both |
| Have you ever had ear surgery? | Yes/no | Right | Left | Both |
| Has anyone in your family had ear surgery or early onset hearing loss? | Yes/no | | | |
| Do you frequently take Aspirin? | Yes/no | | | |
| Do you drink large amounts of coffee or tea? | Yes/no | | | |
| Have you been exposed to loud noises (machinery, gunfire, music)? | Yes/no | | | |
| Are you unhappy with the external or cosmetic appearance of the ear? | Yes/no | | | |
| Do you have dizziness or vertigo? | Yes/no **If yes, please circle the symptom(s)that describe your dizziness:** | | | |

- Lightheadedness, "drunk feelings".
- Blacking out, fainting, or loss of consciousness
- Objects spinning around you.
- Swimming sensation in the head.
- You are spinning inside.
- Unsteadiness.
- Nausea, vomiting.
- Tendency to fall.
- Rocking or floating

| | |
|---|---|
| Is your dizziness constant or nearly constant? | Yes/no |
| Do you get a headache associated with your dizziness? | Yes/no |
| Does your dizziness occur in "attacks"? | Yes/no |
| If yes, how many times per month? _____ | |
| How long does a typical attacks last?______ | |
| Did you get dizzy from arising from bed or from a chair? | Yes/no |
| Does rolling over in bed make you dizzy? | Yes/no |

**************************************************************************************************

- ## ANSWER THE FOLLOWING QUESTIONS IF YOUR SYMPTOM IS SINUS OR NOSE RELATED.

Do you have nasal drainage? Yes/no
**If yes, is it clear/purulent/bloody.**
Have you ever broken your nose? Yes/no
Do you have problems with the sense of smell Yes/no
Do you have headaches? Yes/no
Are there any smokers in the household? Yes/no
Do you have difficulty breathing through your nose? Yes/no
Is your nasal obstruction only on one side of the nose? Yes/no
**Right Left Both**
Have you ever seen an allergist? Yes/no
Have you ever taken allergy shots? Yes/no
Have you ever seen a pulmonologist? Yes/no
Have you ever had prior nasal or sinus surgery? Yes/no
Have you ever used nasal sprays? Yes/no
**Which ones?** ______________________
Have you ever used oral steroids? Yes/no
Have you ever used long-term antihistamines or decongestants? Yes/no
During the past 12 months, how often have you been treated with antibiotics? ______________
Are your nasal/sinus symptoms seasonal? Yes/no
Do you snore or have sleep apnea? Yes/no
Do you have eye or vision problems? Yes/no
**************************************************************************

- ## ANSWER THE FOLLOWING QUESTIONS IF YOUR SYMPTOM IS SNORING OR SLEEP APNEA RELATED.

Have you ever been diagnosed with sleep apnea? Yes/no
<u>If yes, it is important that you bring a copy of your sleep study to your appointment.</u>
**<u>Evaluation of snoring (circle one):</u>**

- 0 No noticeable snoring.
- 1 Occasional soft snoring, intermittent snoring present, but does not awaken bed partner.
- 2 Persistent soft snoring, constant snoring present, but does not awaken bed partner.
- 3 Persistent loud snoring, snoring loud enough to awaken bed partner.

4 Persistent terrible snoring, snoring continuous and so loud that bed partner leaves room and/or used earplugs.

- 5 Heroic snoring, snoring continuous and so loud that it can be heard in a adjacent room.

Are you unable to share a hotel room with a travel companion? Yes/no
Do you snore while sleeping on your: **Back**
**Stomach**
**Side**

Do you have difficulty waking up in the morning? Yes/no
Do you have difficulty staying awake during the day? Yes/no
Do you have difficulty with your memory? Yes/no
Do you have difficulty breathing through your nose? Yes/no
Are you a mouth breather at night (dry mouth in the morning)? Yes/no
Do you have excessive movement or jerking movements at night? Yes/no
Do you awaken gasping for air? Yes/no
Do you awaken with your heart pounding? Yes/no
Do you have narcolepsy (falling asleep involuntarily during the day)? Yes/no
Do you have periods of breathing holding or do you stop breathing while sleeping? Yes/no

****************************************************************************

- **ANSWER THE FOLLOWING QUESTIONS IF YOUR SYMPTOM IS THROAT, VOICE, OR SWALLOWING RELATED.**

Have you had frequent tonsil infections? Yes/no How many in the past year?__________
Do you have difficulty swallowing? Yes/no Liquids Solids Both
Do you have pain when you swallow? Yes/no
Do you choke when you eat? Yes/no
Does food go down the "wrong tube"? Yes/no

**************************************************************************

- **ANSWER THE FOLLOWING QUESTIONS IF YOUR SYMPTOM IS A SWELLING OR MASS IN THE HEAD AND NECK.**

How long have you noticed the mass or swelling?________
Does it's size fluctuate? Yes/no
Is the mass tender? Yes/no
Do you, or do you have a family history of thyroid disease? Yes/no
Do you have ear pain? Yes/no
Do you have pain when you swallow? Yes/no
Do you cough up blood? Yes/no
Have you had a change in your voice? Yes/no
Have you had fevers or night sweets? Yes/no
Have you noticed other masses or swelling in other parts of the body? Yes/no

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IS THERE ANYTHING ELSE OR OTHER INFORMATION THAT YOU WOULD LIKE US TO
KNOW?____________________________________________________________
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