



HEAD & NECK ASSOCIATES OF ORANGE COUNTY, INC.
Bredenkamp | Cho | Crockett | Jakobsen | Luu | Mundi | Supance | Thompson | Wells | Wohlgemuth

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 CAUCASIAN PACIFIC ISLANDER OTHER _____
ETHNICITY: HISPANIC/LATINO 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
biopsies*

*ultrasounds
fiberoptic nasal endoscopy*

*hearing tests
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)

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. _____
2. _____
3. _____
4. _____
5. _____
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

Gastrointestinal:

- Abdominal Pain
- Constipation
- Diarrhea
- Vomiting

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

Respiratory:

- Cough
- Snoring
- Wheezing
- Shortness of breath

Neurological:

- Trouble walking
- Non-restorative sleep
- Fainting
- Tingling

Genitourinary:

- Change in urinary color
- Increased urgency
- Blood in urine
- Pain when urinating

Cardiovascular:

- Chest Pain
- Palpitations

Psychological:

- Increased anxiety
- Depression
- Behavior changes

Allergy/Immunology:

- Hay fever
- Hives
- Food allergies

Name: _____ Date of Birth: _____

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Anesthesia complications | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches, Migraines | <input type="checkbox"/> Immune Suppression |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disorders |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Reflux (GERD) |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes: Type _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hyperthyroidism | |

Please list any other medical conditions: _____

Past surgeries with approximate dates:

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

Family History:

	Alive?	Age/Age of Death	Cardiac Issues?	Cancer? What Kind?	Anesthetic reaction?	Other:
Mother:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Father:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____