# HNA Allergy & Asthma

## PATIENT INFORMATION

NAME: _____ _____ _____ _____ 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:_____

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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: _____

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## 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: _____

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## 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**

HNA Allergy & Asthma

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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.

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.

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## 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

# HNA Allergy & Asthma

Geeta Venkat, MD
Ashley Sandoval, MD

**You have been referred for allergy testing. You will be skin tested with various allergens on your back and arms. Please follow these instructions so we can make this more comfortable for you.**

1. Diet: You may eat your normal diet
2. If you have long hair, you will need to pull your hair back before testing. If you have hair on your back, please make sure that it is removed prior to your appointment
3. Medications: Please discontinue all antihistamines as they inhibit the results of the allergy test.
4. Please do not use any lotion or oil on your arms or back on the day of the testing.

****Please inform us if you are taking Beta Blockers, high blood pressure medication, or have a heart condition**

Stop **5 days prior** to your testing appointment:

| | | |
|---|---|---|
| Ah-Chew | Chlor-Trimeton | Rynatan |
| Allerest | Claritin (Loratadine) | Seldane |
| Allegra (Fexofenadine) | Claritin-D | Tavist D |
| Benadryl (diphenhydramine) | Dymista | Triaminic |
| Bromfed | Nyquil | Tylenol Sinus |
| Astelin (Azelastine) | Patanase (Otopatadine) | Tylenol PM |
| Astepro | Phenergan | non-prescription cold medicines |

Stop **1 week prior** to testing

Atarax (hydroxyzine), Xyzal (levocetirizine) and Zyrtec (cetirizine)

Medications okay to continue are listed below:

Flonase (fluticasone), Nasonex (mometasone), Rhinocort, Budesonide

Please give our office 24 hours' notice if you are unable to make your appointment

Feel free to call if you have any questions: 949-481-9701

Thank you!

# HNA Allergy & Asthma

## Patient Questionnaire

Name:_____ DOB: _____ Date:_____

| | Mother | Father | Siblings | | | | Children | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age (if alive) | | | | | | | | | | |
| Health(good/bad) | | | | | | | | | | |
| Cancer | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | |
| Diabetes | | | | | | | | | | |
| Heart Issues | | | | | | | | | | |
| Hypertension | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| Epilepsy | | | | | | | | | | |
| Nervous Breakdown | | | | | | | | | | |
| Asthma, hives, hayfever | | | | | | | | | | |
| Blood disease | | | | | | | | | | |
| Age (at death) | | | | | | | | | | |
| Cause of death | | | | | | | | | | |

## Personal History

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

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

**Respiratory:**
Snoring
Wheezing
Shortness of breath

**Cardiovascular:**
Chest Pain
Palpitations

**Gastrointestinal:**
Abdominal Pain
Constipation
Diarrhea
Vomiting

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

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

**Psychological:**
Increased anxiety
Depression
Behavior changes
Increased stress

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

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

# HNA Allergy & Asthma

Past Medical History: Please **check** what you have been diagnosed with

- ☐ Anesthesia Complications
- ☐ Anxiety
- ☐ Asthma
- ☐ Kidney disease
- ☐ Bleeding Disorders
- ☐ Cataracts
- ☐ Congestive Heart Failure
- ☐ Cancer: Type_____
- ☐ Diabetes: Type_____
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Immune Suppression
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Reflux (GERD)
- ☐ Enlarged glands
- ☐ Irregular bowel movements

**Please list any other medical conditions**: _____
_____
_____

Please list all **Allergies** (i.e. medications, foods, household products, etc)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list **ALL** surgeries **AND** hospitalizations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list **ALL** diagnostic/radiological tests and **WHY** they were done:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

# HNA Allergy & Asthma

Do you exercise adequately? **NO** **YES, how?**_____

Do you sleep well? **NO** **YES**

How many hours per night do you sleep? _____

Do you have regular bowel movements?_____

Is sex satisfactory? **NO** **YES**

Do you like your work? **NO** **YES**

Do you work Indoors or outdoors?_____

How many hours a day do you watch TV? _____

How many hours a day do you read? _____

How many weeks in a year do you take vacation? _____

Have you ever been treated for alcoholism? **NO** **YES**

Have you ever been treated for drug abuse? **NO** **YES**

Please list **ALL** medications/supplements you take:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Do you often feel any of the below emotions?

- □ Depressed
- □ Anxious
- □ Irritable
- □ Jumpy
- □ Jittery
- □ Trouble concentrating

Completed by □ Patient or_____ Relationship_____

Reviewed by:_____ Date Reviewed: _____

# HNA Allergy & Asthma

**Nasal/Sinus Worksheet**

Name:_____ DOB:_____ Date_____

Do you have nasal obstruction/blockage/congestion:

- □ Yes, which side is worse ❒ right ❒ left ❒ both
- □ No

Do you use nasal sprays?

- □ Never
- □ Currently name of spray_____
- □ In the past name of spray_____

How many sinus infections have you been treated for in the past year? _____

Have you has a recent CT or MRI of your head/sinuses?

- □ No
- □ Yes Date_____ Location _____

Please check all symptoms that apply

- □ Nasal drainage
- □ Decreased sense of smell
- □ Headache, location_____
- □ Postnasal drainage
- □ Facial ❒ pain ❒pressure ❒ fullness
- □ Sneezing
- □ Itchy eyes or nose
- □ Watery eyes or nose

Have you ever been tested for allergies? ❒ Yes, result:_____

❒ No

Have you ever had allergy shots (allergy immunotherapy)?

❒ Yes, for how long?_____ Date stopped_____

❒ No

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***For office use only***

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**Diagnosis:**

**Today's treatment:** **Aims of treatment:**

**L-M score:**

Reviewed by:_____Date Reviewed:_____

# HNA Allergy & Asthma

## Sino-Nasal Outcome Test (SNOT 22)

Please circle the number that best describes your symptoms over the past **2 weeks.**

| Use this scale to describe how bad the problem when it occurs → | No Problem | Very mild problem | Mild or slight Problem | Moderate problem | Severe problem | Worst the problem can be |
|---|---|---|---|---|---|---|
| Need to blow nose | 0 | 1 | 2 | 3 | 4 | 5 |
| Sneezing | 0 | 1 | 2 | 3 | 4 | 5 |
| Runny Nose | 0 | 1 | 2 | 3 | 4 | 5 |
| Cough | 0 | 1 | 2 | 3 | 4 | 5 |
| Post-Nasal drainage | 0 | 1 | 2 | 3 | 4 | 5 |
| Thick nasal discharge | 0 | 1 | 2 | 3 | 4 | 5 |
| Ear fullness | 0 | 1 | 2 | 3 | 4 | 5 |
| Dizziness | 0 | 1 | 2 | 3 | 4 | 5 |
| Ear pain/pressure | 0 | 1 | 2 | 3 | 4 | 5 |
| Facial pain/pressure | 0 | 1 | 2 | 3 | 4 | 5 |
| Difficulty falling asleep | 0 | 1 | 2 | 3 | 4 | 5 |
| Waking up at night | 0 | 1 | 2 | 3 | 4 | 5 |
| Lack of a good night's sleep | 0 | 1 | 2 | 3 | 4 | 5 |
| Waking up tired | 0 | 1 | 2 | 3 | 4 | 5 |
| Fatigue during the day | 0 | 1 | 2 | 3 | 4 | 5 |
| Reduced productivity | 0 | 1 | 2 | 3 | 4 | 5 |
| Reduced concentration | 0 | 1 | 2 | 3 | 4 | 5 |
| Frustrated/restless/irritable | 0 | 1 | 2 | 3 | 4 | 5 |
| Sad | 0 | 1 | 2 | 3 | 4 | 5 |
| Embarrassed | 0 | 1 | 2 | 3 | 4 | 5 |
| Loss of smell/taste | 0 | 1 | 2 | 3 | 4 | 5 |
| Congestion/obstruction of nose | 0 | 1 | 2 | 3 | 4 | 5 |

Reviewed by:_____Date Reviewed:_____

# HNA Allergy & Asthma

***Only applies to patients with Medicare coverage***

**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 physician(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/or non-covered services. Deductible and co-insurance 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.

**HNA Allergy & Asthma**

**Geeta Venkat, MD**
**Ashley Sandoval, MD**

_____ _____
**Signature of Patient** **Date Signed**

_____
**Medicare Number (Required)**