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:_____

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**

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.

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

Patient Questionnaire

Name: _____ DOB: _____ Date: _____

Pharmacy Name & Address: _____ Pharmacy Phone: _____

Primary Care Doctor (first and last name): _____ Office Phone: _____

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

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

Reason for Visit today: _____ Date of Injury: _____

Covid-19 Vaccination Status ☐ Yes ☐ NO If yes, please provide us with a copy of your card.

Number of vaccine doses: _____. Date of Last dose: _____

Personal History

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

How long have you experienced your symptoms? _____

Are symptoms worse during any particular season?_____ ☐ year-round?

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
Nasal Congestion
Nosebleeds
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

Ashley Sandoval, MD
Geeta Venkat, 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

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. _____

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. _____

Do you often feel any of the below emotions?

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

Family History:

	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				

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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

For office use only

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

Ashley Sandoval, MD
Geeta Venkat, MD

_____ _____

Signature of Patient **Date Signed**

_____

Medicare Number (Required)