# Philip Chironis, M.D. Medical Corporation

## Patient Information

Patient Name ______________________________________________________________

Gender: Male _______ Female _______ Date Of Birth ____________________________

Street Address _____________________________________________________________

City ___________________________________ State ________ Zip Code _________________

Primary Phone (_____)________-_______________ Cell Work Home

Secondary Phone (_____)________-_______________ Cell Work Home

Email ______________________________________________________________________

Patients Employer ___________________________________________________________

City, State & Zip Code _______________________________________________________

Occupation _________________________________________________________________

Work Phone (_____)________-_______________ Length Of Employment ___________

Insurance ____________________________________________ Effective Date ____________

Subscriber ________________________________ Patient Relation To Subscriber ___________

Subscriber Social Security ____________________-____________-_________________________

Subscriber's Employer ________________________________________________________

City, State & Zip Code _______________________________________________________

Primary Pharmacy _____________________________ Phone (_____)________-_____________

Pharmacy Address ___________________________________________________________

## Emergency Contact Information

Name ______________________________________________ Relation ________________

Phone (_____)________-_______________

Patient Signature ____________________________________________ Date ______________

(Or Guardian signature for patients under 18 years old)

# Philip Chironis, M.D. Medical Corporation

## Treatment Agreement Form

Patient Name ______________________________________________________________

PRIVATE UNDEMNITY INSURANCE PLANS: As a courtesy, this office provides insurance billing at no charge. However, you are personally responsible for payment of all service(s) rendered and we will look to you for payment if your insurance company does not pay in a timely manner.

HEALTHPLAN MEMBERS (PPO, EPO, POS, HMO etc.): As specified by our contract with your insurance carrier, all billing will be done for you by this office. However, you are personally responsible for all applicable deductibles, co-insurance, co-payments and any services denied as not a covered benefit by your health plan carrier.

_____________ Initials

### Authorization to Release Information and to Pay

Philip Chironis, M.D. Medical Corporation:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize payment of medical benefits to Philip N. Chironis, M.D. Medical Corporation for services rendered.

Patient Signature __________________________________________ Date _____________

(Or guardian signature for patients under 18 years old)

### Authorization to Treat and Agreement to Terms of Payment:

I hereby give Philip N. Chironis, M.D. Medical Corporation authorization to care for my medic al needs and/or those of my dependents. In consideration of these services to be rendered to the patient, the undersigned responsible party agrees to pay for these services upon completion of billing and further agree that should he/she default in paying for these services within 90 days of these statements, he/she may be sent to collections and responsible to cover any agency costs including reasonable attorney’s fees.

Patient Signature __________________________________________ Date _____________

(Or guardian signature for patients under 18 years old)

Philip Chironis, M.D.
361 Hospital Road, Suite 522, Newport Beach, CA 92663

Donna Avila – Office Manager – 949-645-5918

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: ___________________________________ Date: _________________________

Print Name: ________________________________Phone (_____)________-_______________

If not signed by guardian of minor patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient ______________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I wish to be contacted in the following manner:

Primary Phone (_____)________-_______________ Cell Work Home

☐ Office may leave message with the name of the medical provider and call back number only

OR

☐ Office may leave messages with detailed information including but not limited to results of testing, procedures, and medical information

Secondary Phone (_____)________-_______________ Cell Work Home

☐ Office may leave message with the name of the medical provider and call back number only

OR

☐ Office may leave messages with detailed information including but not limited to results of testing, procedures, and medical information

Verbal results may be given to ____________________________ Relation _______________

# Newport Beach Hearing Aid Associates

## Hearing Questionnaire

Patient Name: ___________________________________ Today's Date: _______________

Date of Birth:___________________________ Age: _______________

Current Medications: (please list or mark none if no known medication allergies)

_______________________________________________________________________________

Allergic to medications:

_______________________________________________________________________________

Reason for your visit today? (Circle one or both) Hearing Test Hearing Aid Evaluation

Do you or have you experienced any of the following? (circle all that apply)

Hearing Loss Ear Pain Drainage Fullness Dizziness/Vertigo

Eardrum Perforation Ear Surgery Itchy Ears Exposure to Loud Noises Diabetes

Family history of Hearing Loss Stroke Scarlett Fever Mumps Meningitis

Cancer (specific type): ___________________________________

Is your hearing better in one ear? YES NO Which ear? LEFT RIGHT

Do you have tinnitus/ringing in the ears? YES NO Which ear? LEFT RIGHT

Is the tinnitus? (circle one) Constant Intermittent/Occasional

Have you experienced sudden/rapid hearing loss within the past 90 days? YES NO

Do you have hearing aids? YES NO

How often are they worn? ___________________________________

Which ear? LEFT RIGHT BOTH

How old are the hearing aids? ___________________________________

Are you happy with the benefits the hearing aids currently provide? YES NO

If you could change/improve something about your hearing aids, what would you change?

_______________________________________________________________________________

How were you referred to our office?

- { } Physician (please provide name) ___________________________________
- { } Friend/ Other Patient
- { } Insurance
- { } Internet/Website
- { } Local Advertising
- { } Other

Patient Signature: _______________________________________ Date:________________

(guardian signature for patients under 18 years old)

## AUTHORIZATION FOR HEALTH CARE MARKETING COMMUNICATIONS

Philip Chironis, M.D. Newport Beach Hearing Aid Associates Inc. values you as a patient and respects the privacy of your personal and medical information that is disclosed to us in the course of our treatment relationship with you. The law allows us to send written communications to you about your treatment and services we offer, including products. This is a normal part of our provider-patient relationship and no permission is required for us to do so. We believe such communications are valuable part of our relationship with you. HOWEVER, certain types of communications cannot be sent t you unless you provide written authorization to receive them : communications via email providing educational information regarding the Ears, Nose and Throat. We will periodically provide promotional emails regarding monthly/quarterly sales that our office provides throughout the year.

Please circle the one below and add your initials to indicate whether you authorize the health care marketing communications described herein.

I authorize _____________ I do not authorize ____________

Email Address: ______________________________________________________

Philip Chironis, M.D. Newport Beach Hearing Aid Associates to use or disclose my name, mailing address, or email address for the purpose of sending me materials that market or promote educational information regarding Ears, Nose, Throat and promotional emails regarding Monthly/Quarterly sales.

I understand that I have the right to revoke this authorization in writing at any time by sending written notification to PNC and NBHAA at the following address: 361 Hospital Rd. Suite 522, Newport Beach CA 92663. I understand that a revocation is not effective to the extent PNC and NBHAA has already relied on the authorization to use or disclose my health information as described above. This authorization will remain in effect unless revoked in writing.

Patient/Guardian Signature ______________________________ Date ____________

Print Name ____________________________________________ Date ____________