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 _______________

Philip Chironis, M.D. Medical Corporation

Patient Health Questionnaire

Patient Name ______________________________________ Today's Date __________________

Date of Birth _____________________________ Age ____________________

Reasons for your visit today ____

Have you had any of the following: (circle all that apply)

Diabetes, stroke, cancer, heart disease, high blood pressure, kidney problems, lungs problems, fractured bones, visual problems, bleeding problems, AIDS or HIV

If yes to any of the above, please explain ____

Current Medication¨(please list OTC and prescription medications)

____

____

Allergic to Medications: Please list or mark none if no known medication allergies:

____

☐ NONE

Occupation: ___________________________ How Long ______________________

Do you spoke cigarettes Yes No How many packs a day ________________

Do you drink alcohol Yes No How many drinks per week: _____________

Do you use other substances Yes No Type: __________________________________

Height: _____________ Weight: _______________

How were you referred to our office?

- Physician (Please provide name) ____
- Friend/Another Patient
- Insurance
- Internet/Website
- Other: ____

Please list all providers who have previously treated you for these symptoms in the past

____

____

Have you had any recent CT/MRI/US pertaining to today's visit? Yes No

Facility: ____ Date _____________

Patient Signature ____ Date ______________

(Or guardian signature for patients under 18 years old)

Philip Chironis, M.D. Medical Corporation

ENT Questionnaire

Please circle all that apply:

Ears:	Hearing Loss	Left	Right	Both
☐ Check if None	How long have you experienced hearing loss? __________			
	Ringing/Buzzing Noise	Left	Right	Both
	Drainage from Ear	Left	Right	Both
	Ear Pain	Left	Right	Both
	Ear Fullness	Left	Right	Both
	Itchy Ear	Left	Right	Both

Any prior ear surgeries or treatments? If yes please explain below

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Nose:		
☐ Check if None	Bleeding	How Often _________________
	Congestion	
	Facial Pain	
	"Hay Fever"	
	History of Broken Nose	When? ________________
	Nasal Damage	

Any prior nasal surgeries or treatments? If yes please explain below

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Throat:		
☐ Check if None	Pain	Pain Radiates to other areas? _______________
	Difficultly Swallowing	
	Change In Voice	
	Tonsillitis	How many times in the past 12 mos? __________
	Strep Throat	How many times in the past 12 mos? __________
	Post Nasal Drip	
	Sleep Apnea	

Any prior surgeries or treatments? If yes please explain below

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Dizziness:		
☐ Check if None	Feeling of room spinning	How long is each episode ____________
	Imbalance	
	Veering to one side	
	Headaches	
	Migraines	
	Vision changes	
	Tingling/numbness in hands/feet	

Any prior surgeries or treatments? If yes please explain below

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Anything else you think the doctor should know about your health? If yes, please explain:

Patient Signature ____ Date ______________

(Or 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 ____________

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 ____________