DR. MONICA KIEU
FACIAL PLASTIC SURGERY

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 (_____)_____-_____

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Patient Signature _____ Date _____

(Or Guardian signature for patients under 18 years old)

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

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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)

Notice of Privacy Practices

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

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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 _____

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?

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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)

ENT Questionnaire

Please circle all that apply:

Ears:	Hearing Loss	Left	Right	Both
☐	How long have you experienced hearing loss? _____			
Check if None	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

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

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

Throat:	Pain	Pain Radiates to other areas? _____
☐	Difficultly Swallowing	
Check if None	Change In Voice	
	Tonsillitis	How many times in the past 12 mos? _____
	Strep Throat	How many times in the past 12 mos? _____

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Post Nasal Drip
Sleep Apnea

Any prior surgeries or treatments? If yes please explain below

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

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., Monica Kieu, 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: _____ _____

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Philip Chironis, M.D., Monica Kieu, 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, MCK 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, MCK 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 _____

Cosmetic Interest Questionnaire

Dear Patient and Friend: If you are interested in any of our cosmetic products or services, please take a moment to fill out your PREFERRED contact information. This will make you eligible to receive our monthly newsletter and special offers via email/text.

PLEASE CHECK ONE: € Yes, please! € No, thank you

Name: _____ Date: _____

Sex: ☐ Male ☐ Female DOB: _____

Preferred Method of Contact (Please Circle): Home phone Cell Email Text

Email: _____

€ Facial Lines/Wrinkles	€ Age Spots/Liver Spots	€ Acne/Large Pores
€ Eyelids	€ Neck Lines	€ Acne Scarring
€ Brow position	€ Double Chin	€ Hair Loss
€ Nose	€ Thin Lips	€ Scar Appearance

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€ Facial volume loss	€ Skin texture/firmness	€ Other:_____

Home Phone: _____ Cell: _____

Please check any areas of concern:

Please check any cosmetic services you are interested in learning more about:

€ Botox/Dysport/Xeomin € Fillers (Juverm, Restylane) € Rhinoplasty € Eyelid Surgery € Earlobe surgery € Facial implants	€ Facelift/Necklift € Browlift € Chemical Peels € Lip lift € Submental liposuction € Kybella	€ Micro-needling € PRP (platelet rich plasma) € Hair Restoration € Skin Care Products/Skin Care Advice € Other:_____

Thank you!