

PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below

PATIENT'S PERSONAL INFORMATION

Dr. Mr. Mrs. Ms. Miss (please circle one)

Name: _____ Date of Birth: ____/____/____ Age: ____
Last Name First Name Initial

Nickname? _____ Marital Status: Single Married Divorced Widowed

Street Address: _____

Home Phone: (____) _____ Cellular Phone: (____) _____
City State Zip

Work Phone: (____) _____ Cellular Service Provider: _____

Email Address: _____ Messages can be left at: Home Cellular Work

Last 4 digits of SSN: _____ Allergies: _____

Your employer/ occupation: _____

Will you be responsible for your account? YES If no, please tell us name of person
responsible: _____ Phone number: (____) _____

Spouse's information: _____
Last Name First Name Initial Date of Birth Social Security #

Spouse's Employer's name: _____ Phone number: (____) _____

Street Address: _____
City State Zip

PATIENT'S REFERRAL INFORMATION

How did you hear about Dr. Kosins/ Sara Katenbach : _____

If referred by a friend, may we thank her or him? YES NO

PATIENT'S INSURANCE INFORMATION

Name of Insured: _____ Your relationship to insured: _____

PRIMARY insurance company's name: _____ Phone number: (____) _____

Insurance billing address: _____

Insurance ID #: _____ Insured's SSN: _____ Insured's date of birth: _____
City State Zip

Any SECONDARY insurance? _____

EMERGENCY CONTACT INFORMATION

Name of person not living with you: _____ Relationship: _____

Street Address: _____

Home Phone: (____) _____ Cellular Phone: (____) _____
City State Zip

Financial Agreement I, _____, understand that I am financially responsible for all charges whether or not they covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Date _____ Signature _____

For Office Use Only:

Information Updated: _____

MEDICAL HISTORY AND PRE-ANESTHESIA QUESTIONNAIRE

Name: _____ **Date of Birth:** ____ / ____ / ____ **Age:** ____
Last Name First Name Initial

Sex: FEMALE / MALE **Height:** _____ **Weight:** _____

I. MEDICAL HISTORY

Do you have any of the following:

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble –murmur, palpitations (arrhythmia), pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain (angina), heart attack, heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever, rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, T.B., lung problems, shortness of breath with walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder, anemia, clotting problems, phlebitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure, epilepsy, convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells, blackouts, stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid condition, goiter |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice, hepatitis, liver problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney, bladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor wound healing, radiation treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal response to cold, Raynaud's disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis, scleroderma, collagen disease, lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin pigment problems, keloid, poor scarring |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever blisters, cold sores, herpes simplex |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent infections or boils |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Significant emotional problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric care |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fever or cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant now? |

II. PAST NASAL HISTORY

Medical History: Allergies _____

Nasal Medications _____

Nasal Fractures _____

Have you had any fillers injected into nose (*Restylane, Juvederm, Artecoll, Radiesse, etc.*) **YES / NO** If yes, when? _____

Please list ANY and ALL Nasal Surgeries: (*including Septoplasty, Rhinoplasty, etc.*)

	YEAR	GENERAL/LOCAL ANESTHETIC

III. PAST MEDICAL HISTORY

Have you had any illnesses of the following: (please circle)

Heart	Lungs	Kidneys	Chest	Stomach	Eyes
Ears	Nose	Throat	Brain	Intestines	Arms
Hands	Legs	Nerves	Reproductive System		

Operations/ Injuries: _____

Year _____ General/ Local Anesthetic _____

Year _____ General/ Local Anesthetic _____

IV. RECENT EXAMINATIONS

	YES	NO	DATE
History and Physical	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
EKG (Electrocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lab work	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you under medical treatment? If yes, please explain:

V. MEDICATIONS

Are you sensitive or allergic to:

YES	NO	YES	NO	YES	NO				
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local/ General Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Adhesive Tape

Any other medication or food allergies – please list:

Are you taking or have you taken in the last 6 months any of the following:

YES	NO	YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or aspirin containing products?	<input type="checkbox"/>	<input type="checkbox"/>	Steroids, cortisone or ACTH?
<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers or sedatives?	<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants, blood thinners?
<input type="checkbox"/>	<input type="checkbox"/>	Insulin?			
<input type="checkbox"/>	<input type="checkbox"/>	Any other medication, drugs or eye drops?	_____		

VI. SOCIAL HISTORY

Approximate daily consumption of : Alcohol _____ Tobacco _____ Coffee _____

VII. FAMILY HISTORY

Has any relative ever had:

YES	NO	YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis, scleroderma, lupus
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental disease
<input type="checkbox"/>	<input type="checkbox"/>	Reaction to anesthesia			

VIII. ANY OTHER INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW?

*If any of the above information changes, please inform the doctor.

Form completed by: _____ Date: _____

(Patient's Signature)

**Aaron M. Kosins, MD
Sara Katzenbach, RN
Roxanne Wimmer, LE**

**1441 Avocado Avenue, Suite 203
Newport Beach, CA 92660
Phone (949) 721-0494**

Acknowledgement of Notice of Privacy Practices

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for:

Aaron M. Kosins, MD
Sara Katzenbach, RN
Roxanne Wimmer, LE

Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy Practices is available in our office and on each physician's website listed below. You may request a copy of the Notice of Privacy.

Aaron M. Kosins, MD www.aaronkosinsmd.com
Sara Katzenbach, RN
Roxanne Wimmer, LE

Signature of Patient /Patient Representative

Date

Name of Patient/ Patient Representative (please print)

Relationship to Patient

Online Communication Form

Online communication is a form of communication using “secure” Web sites or email applications that apply appropriate encryption technology designed to protect the transmission of confidential information. Online communication is an additional option for communication along with telephone, mail, and in-person. It is not meant to replace other forms of communication with the doctor.

Patient’s Initials

- _____ The details of online communication have been explained to me in terms I understand.
- _____ Alternative methods of communication (i.e., telephone, in-person, mail) are still available to me.
- _____ I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:
- It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.
 - Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.
 - I will use a secure network. I will not use standard email or email systems provided by employers. I understand that employers have a right to inspect and keep online communications become part of my medical record.
- _____ I agree to take precaution to keep online communication confidential, including but not limited to the following:
- I will keep my password confidential.
 - I will not store messages on an employer-provided computer.
 - I will not leave messages on my screen for others to read.
 - I will review my messages before sending to make sure that they are clear and that all relevant information is included.
 - I will update my contact information as soon as it changes.
- _____ I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me.
- _____ I agree to follow the procedure that the doctor implements to allow him/her to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication.
- _____ I understand that online communication cannot be used for emergencies or time sensitive matters.
- _____ I understand that online communication cannot be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.)
- _____ I have informed the doctor of other treatments I do not want transmitted via online communications.
- _____ I understand that it is my responsibility to determine if an unanswered online communication was received.
- _____ I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication.

Again, please note that online communication should never be used for emergency communications or urgent requests. These should occur via telephone or be using existing emergency communication tools.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature.

For online communication between: _____ and staff and _____.
(Doctor’s name) (Patient’s name)

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

_____ copy given to patient
initial

_____ original placed in chart
initial

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Authorization to Release Protected Health Information (PHI)
to Family Members or Designated Individuals

HIPAA Laws prevent us from discussing or disclosing your protected health information to family members, friends or other designated individuals unless you provide AKMD with authorization to release this information. We are required to have a completed Authorization on file prior to releasing your protected health information.

DESIGNATION OF FAMILY MEMBERS, FRIENDS OR OTHER INDIVIDUALS

Please complete this form to designate the individual(s) to whom we may release your Protect Health Information. Your Protected Health Information includes your medical and billing records maintained by AKMD.

I, _____
Printed Name of Patient (First Name, Middle Initial, Last Name) Date of Birth
authorize AKMD to disclose my protected health information to the individual(s) listed below:

Name	Phone #	Relationship to Patient

I understand that this Authorization is voluntary and I may revoke my authorization in writing at any time, except to the extent that action has been taken by AKMD in reliance on this authorization. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the individuals listed and no longer protected under federal Law.

I also understand that by signing this form all prior Authorizations to Release Protected Health Information to Family Members or Designated Individuals are null and void as of my signature date below.

Signature: _____
Signature of Patient or Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable) _____

If representative, specify relationship to the individual and attach legal documentation of your authority:

- Legal Guardian Power of Attorney Other

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Preferred Pharmacy Information

Beginning January 1, 2022, all prescriptions issued by a licensed prescriber will need to be done electronically pursuant to Assembly Bill (AB) 2789.

Pharmacy Name: _____

Street Address: _____ State _____ Zip Code _____

Phone Number: _____

If you are unable to provide a pharmacy, we will electronically send your prescriptions to Hill Pharmacy Newport which is located on the first floor of our building.

Hill Pharmacy Newport

1441 Avocado Ave #101,
Newport Beach, CA 92660

(949) 640-6564