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:_____
City State Zip

Home Phone: (_____**)**_____ **Cellular Phone: (**_____**)**_____

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: _____
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:_____
City State Zip
Insurance ID #:_____**Insured's SSN:**_____**Insured's date of birth:**_____
Any SECONDARY insurance?_____

EMERGENCY CONTACT INFORMATION

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

Street Address:_____
City State Zip
Home Phone: (_____**)**_____ **Cellular Phone: (**_____**)**_____

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	
☐	☐	High Blood Pressure
☐	☐	Heart Trouble –murmur, palpitations (arrhythmia), pacemaker
☐	☐	Chest pain (angina), heart attack, heart failure
☐	☐	Scarlet fever, rheumatic fever
☐	☐	Asthma, T.B., lung problems, shortness of breath with walking
☐	☐	Blood disorder, anemia, clotting problems, phlebitis
☐	☐	Seizure, epilepsy, convulsions
☐	☐	Fainting spells, blackouts, stroke
☐	☐	Frequent or severe headaches
☐	☐	Diabetes
☐	☐	Thyroid condition, goiter
☐	☐	Cancer
☐	☐	Jaundice, hepatitis, liver problems
☐	☐	Kidney, bladder problems
☐	☐	Poor wound healing, radiation treatment
☐	☐	Abnormal response to cold, Raynaud's disease
☐	☐	Rheumatoid arthritis, scleroderma, collagen disease, lupus
☐	☐	Skin pigment problems, keloid, poor scarring
☐	☐	Fever blisters, cold sores, herpes simplex
☐	☐	Frequent infections or boils
☐	☐	Blood transfusion
☐	☐	Significant emotional problems
☐	☐	Psychiatric care
☐	☐	Recent fever or cold
☐	☐	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	☐	☐	_____
Chest X-ray	☐	☐	_____
EKG (Electrocardiogram)	☐	☐	_____
Mammogram	☐	☐	_____
Lab work	☐	☐	_____

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

_____

_____

V. MEDICATIONS

Are you sensitive or allergic to:

YES	NO		YES	NO		YES	NO	
☐	☐	Penicillin	☐	☐	Local/ General Anesthetic	☐	☐	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	
☐	☐	Aspirin or aspirin containing products?	☐	☐	Steroids, cortisone or ACTH?
☐	☐	Tranquilizers or sedatives?	☐	☐	Anticoagulants, blood thinners?
☐	☐	Insulin?			
☐	☐	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	
☐	☐	Cancer, breast cancer	☐	☐	Diabetes
☐	☐	Epilepsy	☐	☐	Rheumatoid arthritis, scleroderma, lupus
☐	☐	Heart disease	☐	☐	High blood pressure
☐	☐	Lung disease, asthma	☐	☐	Kidney disease
☐	☐	Blood disease	☐	☐	Mental disease
☐	☐	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
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
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
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 risk 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

Aaron M. Kosins, MD
Roxanne Wimmer, LE

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

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 individuals(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
Name	Phone #	Relationship to Patient
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

Aaron M. Kosins, MD
Roxanne Wimmer, LE

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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