# Newport Irvine Surgical Specialists

510 Superior Ave #200G
Newport Beach, CA 92663
Phone: 949-791-6767 Fax: 949-791-6768

16300 San Canyon Ave #301
Irvine, CA 92618
Phone: 949-791-6767 Fax: 949-791-6768

## PATIENT REGISTRATION FORM

NAME____________________ AGE_____ BIRTH DATE__________

ADDRESS______________________________

CITY________________ STATE________ ZIP CODE__________

SOCIAL SECURITY NUMBER______________ DL/ID #____________

HOME PHONE______________ WORK PHONE______________

MOBILE______________ EMAIL______________

Ok to leave message at which number (s)?________________

MARITAL STATUS (circle one) Married Single Legally Separated Divorced Widow Domestic Partner

SPOUSE NAME______________ PHONE NUMBER______________

EMERGENCY CONTACT______________ PHONE NUMBER______________

EMPLOYER______________ OCCUPATION______________
WORK ADDRESS____________________________
CITY______________ STATE________ ZIP CODE__________

**Primary Care Physician** ________________
**Referring Physician**________________
**Cardiologist (if applicable)**________________

**PRIMARY INSURANCE INFORMATION**

Insurance Company____________________________

Policy Holder Name________________ Date Of Birth__________
Member ID________________ Group Number__________

**SECONDARY INSURANCE INFORMATION**

Insurance Company____________________________
Policy Holder Name________________ Date Of Birth__________

*Assignment of Benefits*

I hereby authorize ________________ to make payments directly to Newport Irvine Surgical Specialists in my behalf for all surgical and medical expenses incurred by me. I understand that I am financially responsible for all charges, whether or not covered by my insurance compay.

Patient Signature____________________ Date______________

**Newport Irvine Surgical Specialists**
**510 Superior Ave, Ste 200-G**
**Newport Beach, CA 92663**

NAME________________________________________AGE_________BIRTH DATE_________________________

**Current Problem:**

______________________________________________________________________________

Affected Side (if applicable) Right/Left ____________ How Long?___________________________

**Allergies and Reaction:**

**Medical Conditions:** Do you have, or have you had in the past? Please circle your answer:

| | | | | | |
|---|---|---|---|---|---|
| Diabetes Mellitus | Yes | No | Hepatitis/Cirrhosis | Yes | No |
| High Blood Pressure | Yes | No | Gallstones | Yes | No |
| Healing Abnormality | Yes | No | Heart Arrhythmias | Yes | No |
| Kidney Disease | Yes | No | Heart Valve Problems | Yes | No |
| COPD/Emphysema | Yes | No | Coronary Artery Dis | Yes | No |
| Asthma/Bronchitis | Yes | No | Myocardial Infarct | Yes | No |
| Hyper/Hypo Thyroid | Yes | No | Cancer, Type | Yes | No |

_________________

Other medical conditions: Please list all not noted above__________________________________

______________________________________________________________________________

| Previous Surgeries | Year |
|---|---|
| | |
| | |
| | |
| | |

**Social History:** Please indicate use of the following:

| | Yes | No | Quit? When? | Amount Used |
|---|---|---|---|---|
| Tobacco | | | | |
| Alcohol | | | | |
| Drugs | | | | |

**Preferred Pharmacy and Phone Number:**

______________________________________________________________________________

______________________________________________________________________________

**Newport Irvine Surgical Specialists**
**510 Superior Ave, Ste 200-G**
**Newport Beach, CA 92663**

NAME_______________________________________________AGE__________BIRTH DATE________________

**Family History**: Please indicate any diseases or illnesses that run in your family: _______________________________

_____________________________________________________________________________________

*For women*: Last menstrual period:_______________________________ Last pelvic exam ________________

Are you pregnant? Yes No Due Date: ____________________________

## Review of Systems

**Please circle any symptoms listed below that you are currently experiencing:**

**IF ALL NEGATIVE PLEASE CIRCLE: ALL NEGATIVE**

**General:** fever chills weight gain weight loss insomnia fatigue

**Eyes:** Visual loss blurring diplopia/double vision eye pain

**HEENT:** headache loss of hearing/smell ringing ears congestion sore throat Post-nasal drip hoarseness

**Cardio:** chest pain shortness of breath shortness of breath w/exertion palpitations Leg swelling

**Respiratory:** pain with breathing shortness of breath cough wheezing

**GI:** rectal bleeding nausea/emesis abdominal pain difficulty swallowing indigestion Appetite changes generalized bowel dysfunction constipation

**GU:** painful urination frequent urination blood in urine incontinence menstrual pain Vaginal symptoms

**Muscle:** muscle pain muscle weakness

**Skin:** itching skin lesion rash redness or swelling

**Neuro:** headache seizures dizziness gait disturbances

**Psychiatric:** psychiatric problems depression emotional problems

**Endocrine:** hair loss hot/cold intolerance excessive thirst

**Hematology:** easy bruising/bleeding swollen lymph nodes

**Allergy:** Asthma environmental allergies

HOAG HOSPITAL USE ONLY:

☐ *FAX to Pharmacy after admit physician signs*

## PATIENT STATED HOME MEDICATION LIST

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information. BRING THIS FORM WITH YOU TO HOAG.

☐ *Check this box if not on any home medications.*

______________________ [Signature of Patient/Responsible Person]

DESCRIBE ALLERGIES & REACTIONS:

Physician Orders on Hoag Admit

Completed by: ______________________ Date/Time: __________

Source of Medication History: ______________________

| Continue or Formulary Equivalent (circle one) | | Medication | Dose | Route | Freq | Reason for Taking | Dose last taken - RN to Complete | On Discharge: Stop | On Discharge: Continue (Next Dose) |
|---|---|---|---|---|---|---|---|---|---|
| Y | N | 1. | | | | | | | |
| Y | N | 2. | | | | | | | |
| Y | N | 3. | | | | | | | |
| Y | N | 4. | | | | | | | |
| Y | N | 5. | | | | | | | |
| Y | N | 6. | | | | | | | |
| Y | N | 7. | | | | | | | |
| Y | N | 8. | | | | | | | |
| Y | N | 9. | | | | | | | |
| Y | N | 10. | | | | | | | |

Medication Reconciliation on Entry:

______________________ [Physician Signature]

Date/Time: ID#:

DATE TIME T/O FROM

Noted: ☐ CC/RN: ______________ Date/Time: __________

☐ RN: ______________ Date/Time: __________

SIGNATURE/TITLE

Medication Reconciliation on Discharge:

______________________ [Physician Signature]

Date/Time: ID#:

DISCHARGE: PRINT NEW MEDICATIONS AND CHANGES TO ABOVE MEDICATIONS (PROVIDE PRESCRIPTION TO PATIENT)

| Medication | Dose | Route | Freq | Reason | Special Instructions | Medication Schedule | | | | Comments: |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
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| | | | | | | | | | | |

Original to patient on discharge. Line through stopped meds.

Discharge RN: ______________________

Date/Time:

Discharge Physician Signature: ______________________

Date/Time: ID#:

DATE TIME T/O FROM SIGNATURE/TITLE

**MEDICATION RECONCILIATION/ORDERS**

**Hoag Memorial Hospital Presbyterian**

PS 7514 Rev 12/16/10

**PLACE IN FRONT OF PHYSICIAN ORDERS**

Original – Patient Photocopy 1 – Chart Photocopy 2 – Primary Care Physician

Page ____ of ____ Patient Name ______________

[2517]