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:

_____

_____

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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:

Completed by: _____ Date/Time: _____

Source of Medication History: _____

Physician Orders on Hoag Admit

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 SIGNATURE/TITLE

Noted: ☐ CC/RN: _____ Date/Time: _____

☐ RN: _____ Date/Time: _____

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:

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]

Breast Medical History

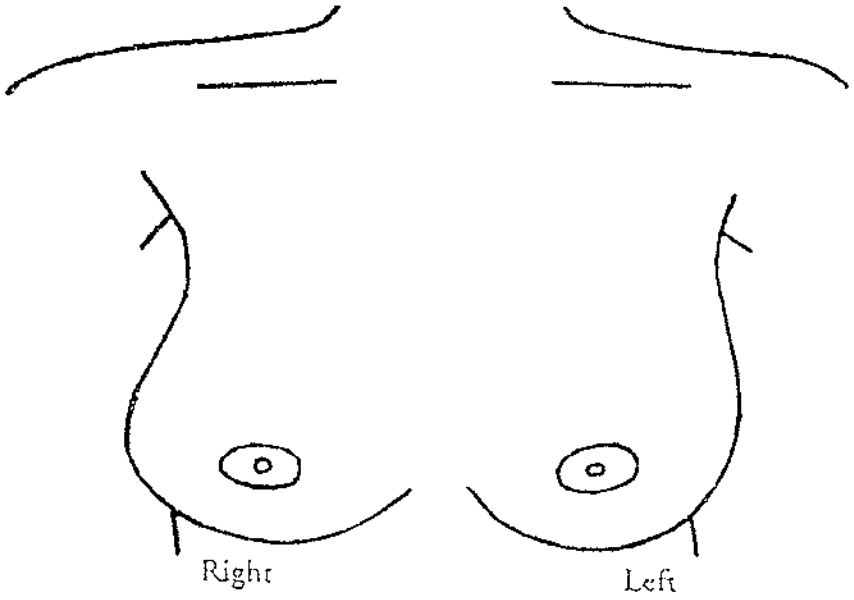
Name: _____ Age: _____ Date: _____

Referring Physician: _____ Primary Physician: _____

Current Problem: _____

_____

Mark size of



Have you had a mammogram or ultrasound to evaluate this? ○ Yes ○ No

If yes, when was it done? _____

Is the current problem noted only on a mammogram? ○ Yes ○ No

Date of last menstrual period? _____

Are you taking oral contraceptives? ○ Yes ○ No

Are you taking estrogen supplements or replacement? O Yes O No

If yes, please list type? _____

How many children do you have? _____

The age of your 1st child? _____

Did you breastfeed? O Yes O No

Age at menarche (first period) _____

Have you had previous breast biopsies? O Yes O No

If yes, how many? _____

Atypical hyperplasia? O Yes O No O Uncertain

Have you been treated for breast cancer in the past? O Yes O No

If yes, what year? _____

Have you had any other breast surgeries? O Yes O No

Have family members been treated for breast cancer? O Mother O Sister

Ovarian cancer or Colon cancer (Note age at diagnosis) O Maternal O Sister

O Grandmother

O Paternal

O Grandmother