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_____

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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

Name: _____ Date: _____

Medical History Questionnaire

Height: _____

Weight: _____

	Yes	No	Brief explanation for YES answers
Glaucoma			
Cataracts			
Other Eye Problems			
Sinus Infections			
Throat Infections			
Ear Problems			
Diabetes			
Thyroid Disorder			
Other Glandular			
Pneumonia			
Asthma			
Bronchitis			
Emphysema			
Tuberculosis			
Shortness of Breath			
Coughing Blood			
High Blood Pressure			
Angina			
Heart Attack			
Congestive Heart Failure			
Irregular Heart Beat			
Heart Murmur			
Rheumatic Fever			
Other Heart Problems			
Nausea/Vomiting			
Hiatus (diaphragmatic) Hernia			
Stomach or Duodenal Ulcer			
Gallstones			
Jaudice			
Hepatitis			
Cirrhosis			
Pancreatitis			
Bladder or Kidney Infections			
Bladder or Kidney Stones			
Blood in the Urine			
Incontinence of Urine			
Venereal Disease			

	Yes	No	Brief expalnation for YES answers
Varicose Veins			
Phlebitis			
Ankle or Foot Swelling			
Pain in leg muscles when walking			
Arthritis			
Back or Spinal Disorder			
Broken Bones			
Artificial (Prosthetic) Joints			
Severe Head Injury			
Seizure Disorder			
Fainting Spells			
Migraine Headaches			
Stroke			
Paralysis			
Other Neuologic Disorder			
Abnormal bleeding tendency after surgery or dental extractions			
Skin Disorder			
Male Patients			
Difficulty with Urination			
Impotence			
Female Patients			
Breast Lumps			
Nipple Bleeding			
Irregular Menstrual Periods			
Abnormal Vaginal Bleeding			
Number of Pregnancies			
Number of Births			
Date of late menstrual period			
Date of last PAP smear			
Age of Menopause			

Describe any adverse reaction to anesthetic (general or local):