

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)? _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

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

SPOUSE NAME _____ PHONE NUMBER _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

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 on 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 company.

Patient Signature _____ Date _____

Newport Irvine Surgical Specialists

510 Superior Ave. Suite 200-G
Newport Beach, CA. 92663

16305 Sand Canyon Ave. Suite 260
Irvine, CA. 92618

Patient Name: _____ **Age:** _____ **DOB:** _____

Reason for Visit: _____

Affected Side (If Applicable) Right or Left: _____ **How Long?** _____

Drug Allergies and Reactions: _____

Pharmacy Name & Phone Number: _____

Medical Conditions: *Do you have or have you had in the past?*

Diabetes Mellitus	Yes	No	High Blood Pressure	Yes	No	High Cholesterol	Yes	No
Hepatitis/Cirrhosis	Yes	No	Kidney Disease	Yes	No	Depression/Anxiety	Yes	No
COPD/Emphysema	Yes	No	Asthma/Bronchitis	Yes	No	Hyper/Hypo Thyroid	Yes	No
Acid Reflux	Yes	No	Gallstones	Yes	No	Gout	Yes	No
Heart Arrhythmias	Yes	No	Heart Valve Problems	Yes	No	Coronary Artery Dis.	Yes	No
Myocardial Infarct	Yes	No	Cancer: _____	Type: _____				

Please list all other medical conditions not noted above: _____

Surgical History

Previous Surgeries:	Year:

Please indicate use of the Following:

Social History:	Yes	No	Quit? / When?	Amount Used
Tobacco				
Alcohol				
Drugs				

Newport Irvine Surgical Specialists

510 Superior Ave. Suite 200-G
Newport Beach, CA. 92663

16305 Sand Canyon Ave. Suite 260
Irvine, CA. 92618

Patient Name: _____ **Age:** _____ **DOB:** _____

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

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	double vision	eye pain			
HEENT	headache	loss of hearing/smell	ringing in ears	congestion	sore throat	post-nasal drip	hoarseness
CARDIO	chest pain	leg swelling	palpitations	shortness of breath	SOB w/ exertion		
RESPIRATORY	pain w/ 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 problem	emotional problems	depression	anxiety			
ENDOCRINE	hair loss	hot intolerance	cold intolerance	excessive thirst			
HEMATOLOGY	easy bruising	easy bleeding	swollen lymph node				
ALLERGIES	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: _____

On Discharge

Continue or Formulary Equivalent (circle one)

Medication	Dose	Route	Freq	Reason for Taking	Dose last taken - RN to Complete
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Stop Continue (Next Dose)

Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N
Y	N

Medication Reconciliation on Entry:
 _____ Noted: CC/RN: _____ Date/Time: _____
 [Physician Signature] ID#: _____
 RN: _____ Date/Time: _____
DATE TIME T/O FROM 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:

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 _____

