NEWPORT IRVINE SURGICAL SPECIALISTS

510 Superior Avenue, Suite 200-G, Newport Beach, CA 92663
16305 Sand Canyon Avenue, Suite 260, 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)?_____

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 compay.

Patient Signature_____Date_____

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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				

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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:

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

[2517]

PLACE IN FRONT OF PHYSICIAN ORDERS

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

Page ____ of ____ Patient Name _____

BREAST MEDICAL HISTORY

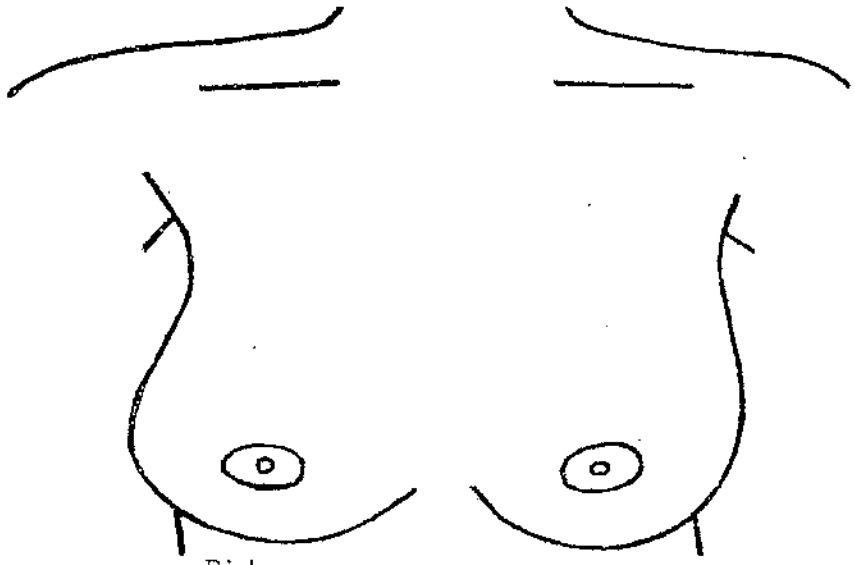
Name: _____ Age: _____ Date: _____

Referring Physician: _____ Primary Physician: _____

Current Problem: _____

_____

Mark size of



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

If yes, when was it done? _____

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

Date of last menstrual period? _____

Are you taking oral contraceptives? O Yes O 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