NEWPORT IRVINE SURGICAL SPECIALISTS

510 Superior Ave. Ste 200G. Newport Beach, CA 92663
16305 Sand Canyon Ave. Ste 260. Irvine, CA 92618
Phone: 949-791-6767 Fax: 949-791-6768

PATIENT REGISTRATION FORM

NAME_____AGE____BIRTH DATE_____Gender*(cirlce one)* M F

ADDRESS_____

CITY_____STATE_____ZIP CODE_____

RACE: *(circle one)* American Indian Asian African Native Hawaiian White Unknown Other_____
ETHNICITY: *(circle one)* Hispanic/Latino Non-Hispanic/Latino

SOCIAL SECURITY NUMBER_____DL/ID #_____

HOME PHONE_____WORK PHONE_____

MOBILE_____EMAIL_____

Ok to leave a detail 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_____

I hereby give permission to contact the above mentioned individual if I cannot be reached. (circle one) ***YES NO***

EMPLOYER_____OCCUPATION_____

WORK ADDRESS_____

CITY_____STATE_____ZIP CODE_____

Primary Care Physician _____
Referring Physician_____
Cardiologist (if applicable)_____

PRIMARY INSURANCE INFORMATION: *(circle one)* HMO POS/PPO Medicare Cash Other

Insurance Company_____

Policy Holder Name_____ Date Of Birth_____

Member ID_____Group Number_____

SECONDARY INSURANCE INFORMATION:*(circle one)* HMO POS/PPO Medicare Cash Other

Insurance Company_____

Policy Holder Name_____ Date Of Birth_____

Member ID_____Group Number_____

I hereby assign my insurnace benefits to be made directly to my physician and any assisting physicians and/or physician assistant, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that ***I am responsible for knowing my benefits/coverage and test ordered by my physician, may NOT be covered****. I will be financially responsible for all charges that are not covered by my insurance company. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical serviced and further treatment. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time of services are rendered. All charges are the direct responsibility of the patient. Newport Irvine Surgical Specialists cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurnace is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.*

Patient Signature_____Date_____

Newport Irvine Surgical Specialists

510 Superior Ave. Suite 200-G
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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:_____	

Personal or Family History of Malignant Hyperthermia Yes No Whom: _____ When: _____

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*

MEDICATION RECONCILIATION/ORDERS
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.***

DESCRIBE ALLERGIES & REACTIONS:

[Signature of Patient/Responsible Person]

Completed by: _____ Date/Time: _____

Source of Medication History: _____

Physician Orders on Hoag Admit: Continue or Formulary Equivalent (circle one)		Medication include vitamins & herbal medications	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:

_____ Noted: ☐ CC/RN: _____ Date/Time: _____
[Physician Signature]

Date/Time: _____ 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

ASSESSMENT

PS 7514 Rev 01/25/19

[2517]

PLACE IN FRONT OF PHYSICIAN ORDERS

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

Page ____ of ____ Patient Name _____

Newport Irvine Surgical Specialists, APC
Elizabeth Arcila, MD
16305 Sand Canyon Ave #260
Irvine, CA 92618
949-791-6767

Dear Patient:

It is my office policy to request that the patient call the office for their X-rays, laboratory or pathology results. Do not assume they are normal if you have not heard from our office. I feel that you should know, and if desired, have copies of all tests performed, but that you should take responsibility to make sure they have been reviewed. If abnormal tests are found, I plan to inform you; however, at times, the results are sent to the wrong physician or to your primary care physician and not this office. By participating in your care and assuring that you know that the tests taken have been received by this office, and reviewed by the physician personally, we can act together as a team to achieve the highest quality health care.

Please sign below so my office is advised that you have been informed of the above policy and understand it fully.

Patient's signature _____ Date _____

Witness signature _____ Date _____

Newport Irvine Surgical Specialists, APC
Elizabeth Arcila, MD
16305 Sand Canyon Ave #260
Irvine, CA 92618
949-791-6767

Dear Patient,

As part of your office examination, you may need to have the following procedures to assist Dr. Arcila with your diagnosis:

1. Abdominal Examination (feeling the tummy)

2. Digital Rectal Examination (finger examination of the anorectal region)

3. Anoscopy (instrument examination of the anal canal)
   This may show up as "SURGERY" on your explanation of benefits

4. Proctoscopy (instrument examination of the rectum)
   This may show up as "SURGERY" on your explanation of benefits

If for any reason, you do not want Dr. Arcila to perform any of these examinations, please inform our office staff.

By signing below, you acknowledge that you have been informed of our procedure policy.

Patient's signature _____ Date _____

Witness signature _____ Date _____