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 insurance 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____________________

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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:__________		

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:

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

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

PS 7514

ASSESSMENT

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 ____________________

BREAST MEDICAL HISTORY

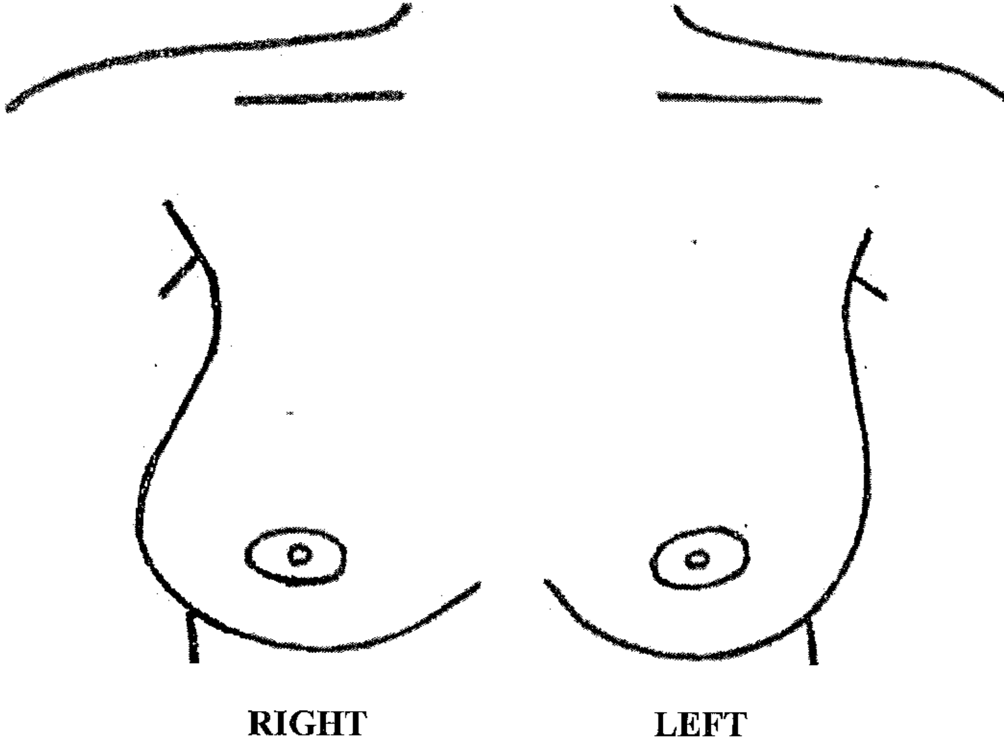
Name: ______________________________ Age: _____ Date: ___________

Primary Care Physician: ________________ Referring 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

Are you taking oral contraceptives? O Yes O No

Date of last menstrual period? _________________

BREAST MEDICAL HISTORY

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

If yes, please list years? ____________________

How many children do you have? ____________________

The age of your first 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? ____________________

Was the diagnosis Atypical Hyperplasia? O Uncertain O Yes O No

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

If yes, what surgery? ____________________

Has any family member been treated for breast cancer? O Yes O No

If yes, whom? Note age of diagnosis?

o Mother o Sister o Maternal Grandmother o Paternal Grandmother

Have any family members been treated for Ovarian or Colon Cancer? O Yes O No

If yes, whom? Note age of diagnosis?

o Mother o Sister o Maternal Grandmother o Paternal Grandmother