



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 *(circle 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 services 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. Insurance 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]

Physician Orders on Hoag Admit

Completed by: _____ Date/Time: _____
 Source of Medication History: _____

On Discharge

Continue or Formulary Equivalent (circle one)

Y	N	Medication include vitamins & herbal medications	Dose	Route	Freq	Reason for Taking	Dose last taken - RN to Complete	Stop	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: _____
 RN: _____ Date/Time: _____
 [Physician Signature] ID#: _____
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

PLACE IN FRONT OF PHYSICIAN ORDERS

PS 7514

Rev 01/25/19

Original - Patient Photocopy 1 - Chart Photocopy 2 - Primary Care Physician
 Page ____ of ____ Patient Name _____



[2517]

Babak N. Rad, M.D., FACS

510 Superior Ave, Suite 200-G

Newport Beach, CA 92663

(949) 791-6767

Dear Patient:

It is my office policy to request that the patient call the office for their X-ray, 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, the results may sometimes be 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 _____



Dear Patient,

As part of your office examination, you may need to have the following procedures to assist Dr. Rad and Dr. Ng 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. Rad/Dr. Ng 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.

(Print Name)

(DOB)

(Signature)

(Date)