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________________

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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]

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

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 _______________