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 insurance information above is accurate and that I am an eligible member. I understand that ***I am responsible for knowing my benefits/coverage and tests 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. Hoag Clinic 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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Newport Irvine Surgical Specialists
510 Superior Avenue, Suite 200G
Newport Beach, CA 92663

Hoag Clinic
Newport Irvine Surgical Specialists
16305 Sand Canyon Avenue, 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					

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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)		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: _____

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

Date/Time: 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

PS 7514 Rev 03/20/24

PLACE IN FRONT OF PHYSICIAN ORDERS

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

Page____of____Patient Name _____

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BREAST MEDICAL HISTORY

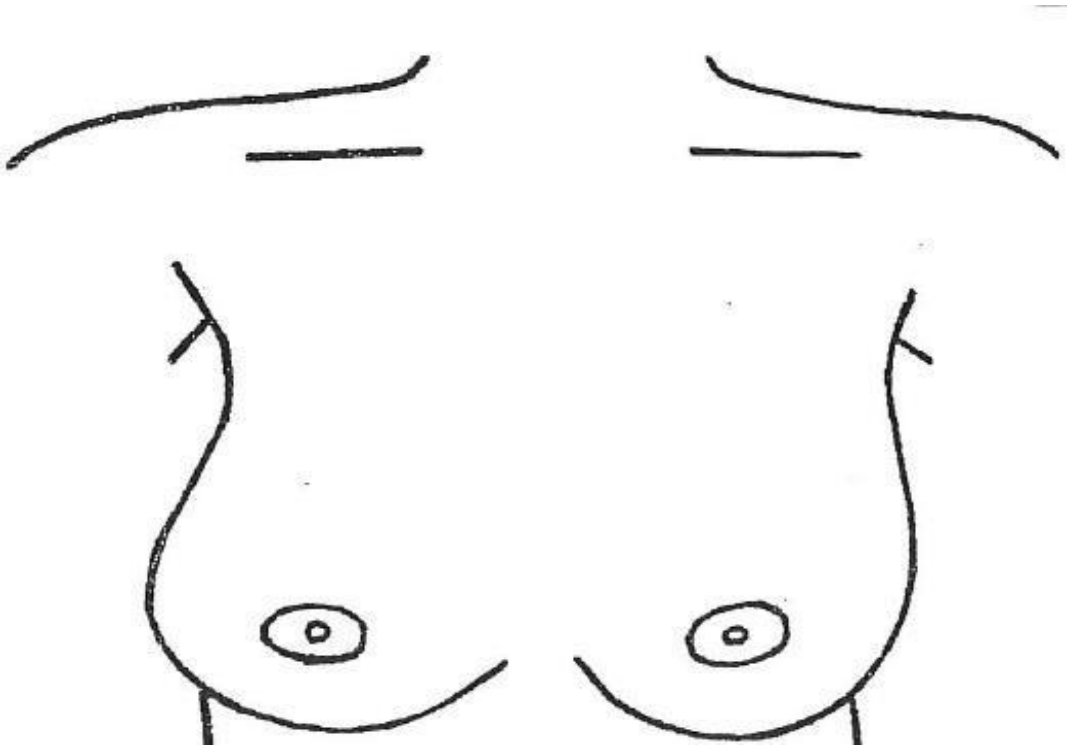
Name: _____ Age: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Current Problem: _____

_____

Mark size of:



RIGHT **LEFT**

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? _____ Age at menarche (first period)? _____

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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

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

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Financial Agreement

Tax ID #33-0676831
NPI #1942799523

We welcome you to our office and would like you to know that we are committed to providing you with the best possible medical and surgical care. To achieve these goals, we need your understanding of our financial policy.

It is the responsibility of the patient to know and understand the policies and benefits of their insurance plans. This includes co-payments, deductibles, contracted providers (Physicians, hospitals, laboratories, radiology, etc.) and the current claims address. Your insurance is a contract between you and your insurance company. We cannot be held responsible for information received when verifying insurance benefits since it is not a guarantee of payment or eligibility. We **strongly encourage** you to contact your insurance company to confirm benefits and coverage.

As a courtesy, our office will bill your insurance company for the services provided. Please present your insurance card(s) for each of your insurance carriers at the time of your visits. If there are changes to your insurance plan(s), please inform us immediately. Please be prepared to present your insurance card(s) at every visit.

The following is a summary of our financial policy:

* **PPO Plans**: We have agreed to contract with several insurance companies but not all. Your deductible, co-insurance, and co-pays are your responsibility and are due at the time of your visit/surgery.

* **Medicare**: We accept assignment from Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance (if any) for the remaining 20% of the Medicare allowed payment as a courtesy. However, you are responsible for the balance regardless of payment from a secondary insurance.

* **HMO Plans (Greater Newport Physicians/Hoag Physicians Partners):** All co-pays must be paid at the time of your visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every billable visit. You are responsible for obtaining approval for treatment with your Medical Group or PCP prior to treatment.

* **Cash Patients**: Payment is due in full at the time services are rendered.

* We accept cash, checks, VISA, MASTERCARD, and DISCOVER CARD.

A $ 25.00 charge will be applied for any returned check.

If you have any questions about the above information, please do not hesitate to contact our billing department.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Name: _____ Signed: _____ Date: _____

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to:
www.mbc.ca.gov,
email: licensecheck@mbc.ca.gov,
or call (800) 633-2322.

_____ _____

Date **Patient's Name (Type or Print)**

_____

Patient's Signature

_____ _____

Date **Patient's Representative's Name and Relationship (Type or Print)**

_____

Patient's Representative's Signature

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov

For information purposes only, a link to the Federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The Federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Patient or Patient Representative:

Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Relationship to Patient: _____