

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 _____



Hoag Clinic
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				



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

hoag. **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: _____						On Discharge	
Continue or Formulary Equivalent (circle one)		Source of Medication History: _____						Stop	Continue (Next Dose)
		Medication include vitamins & herbal medications	Dose	Route	Freq	Reason for Taking	Dose last taken - RN to Complete		
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:				Medication Reconciliation on Discharge:			
_____ [Physician Signature]		Noted: <input type="checkbox"/> CC/RN: _____		Date/Time: _____		_____ [Physician Signature]	
Date/Time: _____		ID#: _____		<input type="checkbox"/> RN: _____		Date/Time: _____	
DATE	TIME	T/O FROM	SIGNATURE/TITLE	DATE	TIME	T/O FROM	SIGNATURE/TITLE

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 Physician Signature: _____
Discharge RN: _____	Date/Time: _____ ID#: _____
Date/Time: _____	DATE TIME T/O FROM SIGNATURE/TITLE

ASSESSMENT	PLACE IN FRONT OF PHYSICIAN ORDERS
PS 7514	Original – Patient Photocopy 1 – Chart Photocopy 2 – Primary Care Physician
Rev 03/20/24	Page ____ of ____ Patient Name _____

Babak N. Rad, M.D., FACS

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.

I plan to inform you if abnormal tests are found; 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)



Hoag Clinic
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

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: _____



Hoag Clinic
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

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: _____

