Northern California Advanced Surgery Center, LP

Patient Registration

Please read carefully before completing form.

We expect an insurance form completed if indicated for your insurance coverage.
We will also need copies of all insurance cards (including Medicare cards).

Patient Name: _____ Age: _____
(Last) (First) Middle)

Date of Birth: ___/___/____ Sex: ☐ Male ☐ Female Telephone: (____) _____
mm / dd / yyyy

Address: _____

City: _____ State: _____ Zip: _____

Patient's Social Security Number: _____-_____-_____ Language Preferred: _____

Employer: _____

Primary Insurance: _____ Medical Group: _____

Secondary Insurance: _____ Medical Group: _____

Third Insurance: _____ Medical Group: _____

Spouse's Name/Guarantor: _____ Guarantor's Date of Birth: _____/_____/_____

Guarantor/Spouse's Social Security Number: _____-_____-_____

Are you living in a skilled nursing facility? ☐ Yes ☐ No

Referring Physician: _____

Primary Medical Doctor: _____

In Case of Emergency—Please list nearest relative/friend we may contact (not living with you).

Name: _____ Telephone: (_____) _____

Insurance Authorization and Assignment

I hereby authorize the Northern California Advanced Surgery Center, LP to furnish information to insurance carriers, and any other physicians involved in my care, regarding my illness and treatments. I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance company.

Date: _____ Signature: _____

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Health Assessment and History

Patient Name: _____ Date of Surgery: _____

MEDICAL HISTORY	None	Comments
□ Stroke □ Seizures	□	
□ Mental Illness □ Claustrophobia □ Depression □ Panic Attacks	□	
□ High Blood Pressure	□	
□ Heart Disease □ Irregular Rhythm □ Heart Attack □ Chest Pain Surgery □ Pacemaker / Implanted Defibrillator	□	
□ Asthma □ COPD/ Emphysema □ Pneumonia / Bronchitis □ Allergies (hay fever/seasonal)	□	Any other breathing problems:
□ Smoker	□	Quit _____(When), _____
□ Liver Problems □ Hepatitis	□	
□ Neck Issues	□	
	□	
□ Reflux □ Indigestion/Heartburn	□	
□ Kidney or Urinary Problems	□	Prostate drugs: □ yes □ no
□ Bowel/ Intestinal Problems	□	
□ Arthritis	□	
□ Prosthesis or Implants	□	
□ **Diabetes**	□	□ Insulin dependent □ non-insulin dependent
□ Thyroid Disease	□	
□ **Sleep Apnea**	□	
□ Bleeding or clotting problems	□	Aspirin, Coumadin, Plavix
□ Family history of anesthesia problems	□	(Nausea, vomiting, hard to wake up, high fevers)

Glaucoma □ Yes □ No □ Right □ Left Jaw Problems/ Pain □ Yes □ No

Previous Cataract

□ Bridges □ Partials □ Crowns □ □ Dentures □ Upper □ Lower

Other Eye surgery □ Yes □ No

Do you have an advanced directive for Healthcare____Yes____No

□ **See Separate Medication List** Primary Care Physician: _____
□ **No Medications Taken**

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ALLERGIES:	Yes/ list	No
LATEX /Rubber		
Dyes / Tape		
Shellfish / Seafood / Foods		
Medication Allergies	List Reaction for each	

Previous Surgeries:

Reviewed By: _____

Signature/ Date_____

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Patient Home Medication List

(Including prescriptions, over the counter, herbals, vitamins and birth control pills or patch)

Medication _____ **Reaction** _____ **Latex Allergy** _____ **Reaction** _____

Allergies _____ _____ **Iodine Allergy** _____ **Reaction** _____

_____ _____

_____ _____

Medication Name	Dose	Frequency	Reason for Taking	Last Taken *(date/time)*	Notes

Pt Uses O2 at home ☐ ____**Lt/min**

Patient Label