Nurick | SURGICAL INSTITUTE

HARVEY A. NURICK, M.D.
DIPLOMATE, AMERICAN BOARD OF SURGERY
GENERAL AND VASCULAR SURGERY

GUSTAVO LARA, M.D.
DIPLOMATE, AMERICAN BOARD OF SURGERY
GENERAL AND VASCULAR SURGERY

AARON LEE, D.O.
DIPLOMATE, AMERICAN OSTEOPATHIC BOARD OF SURGERY
GENERAL AND HPB SURGERY

KEVIN NGUYEN, M.D.
DIPLOMATE AMERICAN BOARD OF SURGERY
GENERAL AND VASCULAR SURGERY

ARAS EMDADI, D.O.
DIPLOMATE AMERICAN BOARD OF SURGERY
BOARD CERTIFIED COLON AND RECTAL SURGERY

Dear:

Your appointment is scheduled with:

☐ **Harvey Nurick, M.D.** ☐ **Gustavo Lara, M.D** ☐ **Aaron Lee, D.O.** ☐ **Kevin Nguyen, M.D.** ☐ **Aras Emdadi, D.O.**

Date:_____ Time:_____AM/PM

Our physicians and staff are committed to providing you with excellent care. Since this may be your first visit to our office we would like to make the process as stress free as possible. In order to make your first appointment as smoothly as possible, please review and complete the following items on this checklist.

☐ ***Please fill out the registration*, medical history, and all authorization forms before arriving to your appointment and be sure to bring them with you on the day of your appointment**

☐ To make registration and insurance billing as efficient as possible, please bring your insurance card (s) and photo ID with you.

☐ If you have a co-payment, this amount will be collected upon your check in. Should you have a share of cost or deductible we will collect this amount upon check out.

☐ **Referral or Authorization** (HMO Plans)
Please bring a copy of your referral from your Primary Care Physician if you have an HMO Plan. It is necessary for you to have a copy of the referral authorization prior to scheduling your new patient appointment.

☐ **Studies** *(If you have had previous studies done prior to your first visit)*:
Please bring a CD/disk of any X-rays, MRIs, CT scans, etc. to the office for your first visit. The disk is necessary for our physicians to provide you with a complete examination. Please contact the radiology group or the hospital where they were performed to obtain these records. They may require 24-48 hr. notice to obtain films. ***(without the films we may find it necessary to reschedule your appointment).***

☐ Please bring a **list** of your current medications including dosages with you to your appointment.

☐ Due to the nature of our surgical practice, there are times when a surgeon may be detained in the operating room or occupied with unforeseen emergencies. We ask that you come prepared with reading material or quiet activities to pass the time as we await the arrival of the surgeon. We will do our best to advise you of potential delays prior to your arrival.

☐ **Policy on *children* in the practice**
Due to the health concerns of our post operative patients and your children, we ask that you make child care arrangements for your children under the age of 16, **unless they are seeing the doctor, they should not accompany you to your appointment.** We appreciate your cooperation in this matter.

We look forward to meeting your healthcare needs. If you should have any questions or need to make changes regarding your appointment, please do not hesitate to call.
Thank you

7111 Indiana Ave Suite 100• RIVERSIDE, CALIFORNIA 92504
(951) 276-9012 • FAX (951) 276-9163

Nurick | SURGICAL INSTITUTE

(For office use only)
☐ New Patient
☐ NP Hosp
Intials: _____

Patient Information

_____
LAST NAME FIRST NAME M.I.

Address: _____City_____ Zip_____

Phone Number: Home:(____) _____ Cell:(____) _____ Cell Carrier: (____)_____

Preferred Language: [ ] English [ ] Spanish [ ] Other_____ **Email Address**:_____

CIRCLE ONE: MISS. MS. MRS. MR. DR. REV. CHILD **CIRCLE ONE:** SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Date of Birth:____/____/_____ Sex: M F Age:_____ Social Security Number:____/_____/_____

Employer: _____Occupation: _____

Business Phone: ( ) _____Ext._____ Drivers Lic#._____

Guarantor Information or Parent if under the age of 18 complete this portion:

Name: _____Soc Sec.No.____/____/_____

Employer: _____ Phone: ( )_____

Relationship to Patient: _____

Emergency Contact Information

Name:_____ Relationship: _____

Address: _____Phone: _____

How did you hear about our office: _____

Who is the physician who referred you to our office: _____Phone:_____

Insurance Information

Primary insurance: _____ **Secondary insurance:** _____

Identification number: _____ Identification number: _____

Group Number: _____Group Number: _____

Subscriber name: _____ Subscriber name: _____

Subscriber Date of Birth: _____/_____/_____ Subscriber Date of Birth: _____/_____/_____

Subscriber Soc Sec.No._____/_____/_____ Subscriber Soc Sec.No._____/_____/_____

Financial Responsibility

1. I accept responsibility for all charges incurred in the medical evaluation and health care of the above named patient.
2. I authorize payment of medical benefits be made directly to the physician provider for services rendered.

Patient Signature_____**Date**_____
Or Authorized Representative signing for the Patient if under 18

Print name: _____**Relationship:** _____

PATIENT MEDICINE LIST/ALLERGY QUESTIONAIRE

Name:_____ Name preference:_____

Date of birth_____ Account #_____(For office use only)

MEDICATION ALLERGIES	REACTION
	I
	I
	I
	I

FOOD AND OTHER ALLERGIES	REACTION
	I
	I

Has a physician ever told you that you have an allergy to latex? □ Yes □ No

MEDICATION HISTORY:

Are you currently taking any of the following medications? Date and time of last dose taken:

Aspirin	□ No □ Yes	____/____/____	Time: _____
Blood thinners	□ No □ Yes	____/____/____	Time: _____
Diet Pills	□ No □ Yes	____/____/____	Time: _____
Herbal supplements	□ No □ Yes	____/____/____	Time: _____

WE WILL BE HAPPY TO COPY YOUR LIST OF MEDICATIONS(OR)PLEASE LIST BELOW:

Name of medication:	Dose	How often	Last dose
1.			
2.			
3.			
4.			
5.			
6.			

Please list **all other** over the counter medications, vitamins and herbal supplements you are taking **without** a prescription:

Name of medication, vitamins, herbal supplements	Dose	How often	Last dose
1.			
2.			
3.			

HEALTH RISKS:

Have you smoked cigarettes in the last year? □ No □ Yes How many a day?_____ How many years?_____

Did you smoke and quit? □ No □ Yes Date that you quit _____/_____/_____

Do you drink alcohol? □ No □ Yes How much?_____ How often?_____ How many years?____

MEDICAL HISTORY: Patient Name: _____ Account # _____

DO YOU HAVE A HISTORY OF:	NO	YES	EXPLAIN
STROKE OR TIA? (Transient Ischemic Attack)			
MENTAL HEALTH PROBLEMS?			
SEIZURE DIORDER? EPILEPSY? NARCOLEPSY?			
WEAKNESS? WHERE?			
NUMBNESS NOW? WHERE?			
NEUROLOGIC PROBLEMS? MIGRAINES?			
SIGHT OR HEARING PROBLEMS? GLAUCOMA? (CIRCLE)			
EAR, NOSE, OR THROAT PROBLEMS? (CIRCLE)			
SLEEP APNEA?			
LUNG DISEASE? (ASTHMA, COPD, EMPHYSEMA)			
BREATHING PROBLEMS?			
HEART PROBLEMS? HEART ATTACK? ANGINA?			
HIGH BLOOD PRESSURE?			
CIRCULATION PROBLEMS? EDEMA OR SWELLING OF FEET?			
NECK, SHOULDER, BACK, HIP OR KNEE PROBLEMS? (CIRCLE)			
PHYSICAL LIMITATIONS?			
BLOOD DISORDER? / BLOOD CLOTS? PHLEBITIS? ANEMIA?			
STOMACH OR DIGESTIVE PROBLEMS? ACID REFLUX? (CIRCLE)			
HEPATITIS? TYPE: A B C (CIRCLE)			
THYROID PROBLEMS?			
PANCREAS OR ADRENAL PROBLEMS? (CIRCLE)			
DIABETES? HOW LONG HAVE YOU BEEN A DIABETIC?			
UNINARY PROBLEMS? DIFFICULTY W/ CONTROL OR INFECTIONS? (CIRCLE)			
KIDNEY PROBLEMS? RENAL DISEASE? KIDNEY STONES?			
DIALYSIS?			
GYNECOLOGICAL / FEMALE PROBLEMS?			
PROSTATE PROBLEMS?			
SKIN PROBLEMS NOW? WOUNDS, SORES, DECUBITUS?			
CANCER NOW OR IN PAST? WHAT KIND?			
ARE YOU PREGNANT?			
ARE YOU HAVING PAIN? WHERE?			
DO YOU HAVE A PACER? IMPLANT? ARTIFICIAL JOINT?			
IMMUNE DISORDER? LUPUS? FIBROMYALGIA? OTHER?			
DO YOU HAVE ANY OTHER PROBLEMS?			

PLEASE LIST ANY SURGERIES:	APPROXIMATE DATE(S):

The information I have provided is true and accurate as of: Date: _____

Signature: _____ Print name: _____

FOR OFFICE USE ONLY

☐ Reviewed by:_____

New Patient Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Harvey Nurick, M.D. Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Harvey Nurick, M.D. Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Sections 164.520 of the Code of Federal Regulations.

I further understand that Harvey Nurick, M.D. Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulation. Should Harvey Nurick, M.D. Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, e-mail).

I grant the office staff and physicians permission to discuss my protected health information and other personal information with the following persons:

Name: _____ Relationship: _____ Phone Number (___)_____

Name: _____ Relationship: _____ Phone Number (___)_____

Name: _____ Relationship: _____ Phone Number (___)_____

I understand that as a part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to other medical entitities, and I consent to such a disclosure for these permitted uses, including disclosures via fax.

I fully understand and ☐ accept ☐ decline the terms of this consent.

Patient Signature _____ **Date** _____
Or Authorized Representative signing for the Patient

Print name: _____ **Relationship**: _____

FOR OFFICE USE ONLY

☐ Consent received by:_____ Date:_____.

☐ Consent refused by patient, and treatment refused as permitted.

PREFERRED PHARMACY

Please complete the information below.

Last	First Name	Middle Initial	Date of Birth

Preferred Pharmacy

Name:_____

Address:_____

City, State, Zip Code:_____

Phone number: _____

Patient Signature: _____ **Date:**_____