Nurick | SURGICAL INSTITUTE

7111 Indiana Ave, Suite 100 • Riverside, California 92504
(951) 276-9012 • Fax (951) 276-9163

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 go as smoothly as possible, please review and complete the following items on this checklist.

BEFORE YOUR APPOINTMENT

- ☐ **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 hours' 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.

Patient Registration

PATIENT INFORMATION

FOR OFFICE USE ONLY ☐ New Patient ☐ NP Hosp Initials: _____

LAST NAME	FIRST NAME	M.I.

ADDRESS	CITY	ZIP

HOME PHONE	CELL PHONE	CELL CARRIER
( )	( )	

PREFERRED LANGUAGE	EMAIL ADDRESS
☐ English ☐ Spanish ☐ Other _____	

TITLE	MARITAL STATUS
☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Rev. ☐ Child	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

DATE OF BIRTH	SEX	AGE	SOCIAL SECURITY NUMBER
/ /	☐ M ☐ F		– –

EMPLOYER	OCCUPATION

BUSINESS PHONE	EXT.	DRIVER'S LICENSE #
( )		

GUARANTOR OR PARENT

Complete this portion if the patient is under the age of 18

NAME	SOCIAL SECURITY NUMBER
	– –

EMPLOYER	PHONE	RELATIONSHIP TO PATIENT
	( )	

EMERGENCY CONTACT

NAME	RELATIONSHIP

ADDRESS	PHONE
	( )

REFERRAL

HOW DID YOU HEAR ABOUT OUR OFFICE?	PHYSICIAN WHO REFERRED YOU TO OUR OFFICE	PHYSICIAN'S PHONE
		( )

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
IDENTIFICATION NUMBER	GROUP NUMBER	IDENTIFICATION NUMBER	GROUP NUMBER
SUBSCRIBER NAME		SUBSCRIBER NAME	
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER SOC. SEC. NO.	SUBSCRIBER DATE OF BIRTH	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 — or authorized representative signing for the patient if under 18

DATE

PRINT NAME

RELATIONSHIP

Medicine List & Allergy Questionnaire

NAME	NAME PREFERENCE
DATE OF BIRTH / /	ACCOUNT # (for office use only)

ALLERGIES

MEDICATION ALLERGIES	REACTION
FOOD AND OTHER ALLERGIES	**REACTION**

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?

MEDICATION	NO	YES	DATE OF LAST DOSE	TIME OF LAST DOSE
Aspirin	☐	☐	/ /	
Blood thinners	☐	☐	/ /	
Diet pills	☐	☐	/ /	
Herbal supplements	☐	☐	/ /	

CURRENT MEDICATIONS

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? _____

Please continue to Medical History on the next page →

Medical History

PATIENT NAME	ACCOUNT # (for office use only)

DO YOU HAVE A HISTORY OF:	NO	YES	EXPLAIN
Stroke or TIA? *(transient ischemic attack)*	☐	☐	
Mental health problems?	☐	☐	
Seizure disorder? 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?	☐	☐	
Urinary problems? Difficulty with 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		APPROX. DATE(S)	SURGERY		APPROX. DATE(S)
1			5		
2			6		
3			7		
4			8		

The information I have provided is true and accurate as of the date below.

SIGNATURE _____ PRINT NAME _____ DATE _____

FOR OFFICE USE ONLY ☐ Reviewed by: _____

Consent to Use & Disclose Health Information

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 Section 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 Regulations. 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 entities, 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 — or authorized representative signing for the patient _____ DATE _____

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.

PATIENT

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
			/ /

PREFERRED PHARMACY

PHARMACY NAME
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER ( )

PATIENT SIGNATURE

DATE