

REGISTRATION

(PLEASE PRINT)

CROWN SURGICAL GROUP

800 Magnolia Ave., Suite 107

Corona, CA 92879

Telephone: (909) 736-0696

Date _____

Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____ Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

CROWN SURGICAL GROUP

Raymund Cordero, M.D.
Francis Essien, M.D.
Yara Gorski, M.D.

Festus Dada, M.D.
Tito Gorski, M.D.
David Suh, M.D.

COMMUNICATION CONSENT AGREEMENT

I, _____ understand that under Federal Law (HIPPA) this medical office may not release any medical information to any individual without my expressed written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore give permission to Crown Surgical Group to release medical information on my behalf to the following person(s).

(1) Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Date of Birth: _____

****FOR IDENTIFICATION PURPOSE ONLY

Driver License # _____ OR Last 4 Digits of Social Security # _____

(2) Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Date of Birth: _____

****FOR IDENTIFICATION PURPOSE ONLY

Driver License # _____ OR Last 4 Digits of Social Security # _____

(3) Name: _____ Relationship: _____

Address: _____

Phone Number: _____ Date of Birth: _____

****FOR IDENTIFICATION PURPOSE ONLY

Driver License # _____ OR Last 4 Digits of Social Security # _____

PATIENT NAME: _____ DOB: _____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT HISTORY FORM

NAME: _____ **AGE:** _____ **DATE:** _____

PRESENT WEIGHT: _____ **LBS** **HEIGHT:** _____

MEDICAL REASON FOR VISIT: _____

ALLERGIES/ SENSITIVITIES TO MEDICATION: _____

PATIENTS MEDICAL HISTORY: (PLEASE CIRCLE Y OR N)

Y / N HEART ATTACK	Y / N ASTHMA	Y / N THYROID PROBLEMS
WHEN? _____	Y / N JAUNDICE	Y / N COLITIS/ COLON POLYPS
Y / N HEART FAILURE	Y / N KIDNEY DISEASE	Y / N ULCER DISEASE
WHEN? _____	Y / N TUBERCULOSIS	Y / N HEPATITIS
Y / N HEART MURMUR	Y / N PHLEBITIS (BLOOD CLOT IN LEG)	Y / N CANCER
Y / N PROSTATE PROBLEMS (STRAINING TO URINATE)	Y / N DIABETES	IF YES: WHAT TYPE? _____
Y / N RHEUMATIC FEVER	INSULIN TYPE / AMOUNT	OTHER _____
Y / N HYPERTENSION	_____	_____

LIST ANY ILLNESSES YOU HAVE BEEN HOSPITALIZED FOR, NOT REQUIRING SURGERY:

PREVIOUS SURGERIES AND APPROXIMATE DATES:

ANY FAMILY HISTORY OF: (PLEASE CIRCLE Y OR N)

Y / N DIABETES	Y / N TUBERCULOSIS	Y / N HIGH BLOOD PRESSURE
Y / N BLEEDING TENDENCIES	Y / N HEART DISEASE	Y / N CANCER
Y / N KIDNEY DISEASE	Y / N STROKE	IF YES: WHAT TYPE? _____

MEDICATIONS:

PRESCRIPTION _____

NON-PRESCRIPTION _____

BLOOD THINNERS _____

DO YOU USE TOBACCO? _____ **IN THE PAST?** _____

DO YOU USE ALCOHOL? _____ **AVERAGE DAILY AMOUNT?** _____