

PATIENT REGISTRATION

Diamond Bar Surgery Center, LLC

PLEASE FILL IN EVERY BLANK

Date of Treatment _____ Ethnicity/ Race _____

PLEASE PRINT

Patients Last Name _____ First _____ Middle _____

Age _____ Birthdate _____ Weight _____ Height _____

Medical Card # _____ Medicare # _____ Male ___ Female ___

Social Security Number _____ Facility Name: _____

PLEASE INCLUDE A LIST OF ALL MEDICATIONS INCLUDING DOSE AND FREQUENCY, PLEASE ATTACH A SEPARATE FORM.

ALLERGIES ___yes ___no (if yes) list all _____

MEDICATIONS ___yes ___no if yes, please provide list including drug name, dosage.

PATIENTS RESIDENCE

___SCF/Skilled Nursing Facility ___Other ___ICF/Intermediate Care Facility

___Resides at Home Address _____

City _____ State _____ Zip Code _____

Phone# _____ Fax# _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____ TEL. () _____

Address _____ City _____ Zip _____

I certify that the above information is true and correct to the best of my knowledge.

Signed By _____ Relationship _____ Date _____
(If signed by other than the patient)

Name of Person Providing Transportation _____ Phone _____

Name of Person whose signs consent _____ Phone _____

Patient Pre-OP Instructions

1. No food or drink after 12:00 midnight the night before surgery
2. Please arrive to **Diamond Bar Surgery Center** between 530am and 700am unless otherwise instructed. The Surgical Center does not open until 530am.
3. A family member/ spouse/ caregiver must accompany you to **Diamond Bar Surgery Center** and must remain with you.
4. No driving, no use of mechanical equipment and no signing of legal documents for 24 hours after surgery.
5. The recovery time after surgery is approximately 30 minutes.
6. Clothing (**wear loose clothing**)
 - **Wear loose pants and short sleeve shirts.**
 - **No belts, please.**
 - **Please do not bring money, jewelry, or any valuables. Diamond Bar Surgery Center will not be responsible for lost or stolen valuables.**
7. Take all medications prescribed by a doctor.
 - If you have an allergic reaction to the medication, STOP all Medication immediately and call **Dr. Brian Adams DSS** at 909-860-7767 or go to the nearest Hospital Emergency Room.
8. If you have any questions please ask the Doctor or Nurse.
9. Please keep your appointment and if you cannot keep your appointment please call to cancel within 72 hours or 24 hours for emergency reasons. A missed appointment fee of \$50.00 will be charged for non-cancelled appointments.
10. _____ I acknowledge that I/patient will have nothing to eat or drink after
(Initial) midnight the night before surgery
11. **If you understand all the instructions**, please sign below:

Signature _____ **Date:** _____
(Patient/Caregiver's / Legal Guardian/ Nearest Relative)

PATIENT PRE-ANESTHESIA QUESTIONNAIRE

Yes NO

- ____ ____ 1. Have you ever had any type of anesthesia in the past?
- ____ ____ 2. Have you or any family member had a problem with anesthesia? If so what problems ? _____
- ____ ____ 3. Do you use any medications, drugs, or eye drops?
IF YES please provide a list of drug name, dosage and frequency
- ____ ____ 4. Female patients of child bearing age: are you pregnant? **Please list the date of last menstrual period** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Yes NO

- ____ ____ High blood pressure?
- ____ ____ Chest Pain (Angina)
- ____ ____ Palpitations (Arrhythmia)?
- ____ ____ Herat attack, Herat failure, or Herat murmur?
- ____ ____ Diabetes?
- ____ ____ Thyroid disease or goiter?
- ____ ____ Asthma, Emphysema, TB or other lung problems?
- ____ ____ Seizures, convulsions, black-outs, fainting spells or stroke?
- ____ ____ Jaundice, hepatitis, or liver problems?
- ____ ____ Bleeding or clotting problems?
- ____ ____ Kidney problems?
- ____ ____ Back pain?
- ____ ____ Do you smoke? How much? _____
- ____ ____ Recent fever, cold, cough, or sore throat?
- ____ ____ Do you drink alcohol? How much? _____
- ____ ____ Do you have any loose teeth, dentures, bridges, capped teeth or crowns?
- ____ ____ Do you use any social or recreational drugs?
- ____ ____ Are you physically active?
- ____ ____ Have you taken aspirin or any blood thinners in the last 7 days?

Date: _____

**SIGNATURE OF PATIENT, CAREPROVIDER
LEGAL GUARDIAN, NEAREST RELATIVE**