ANESTHESIA QUESTIONNAIRE

Date of Procedure/Surgery _____

LAST FOOD	LAST FLUID	BP	PULSE	RESP.	TEMP.	O_2 SAT

I. DRUGS AND MEDICATIONS:
List all medications you take, and the dosage, (including herbal supplements, vitamins, over-the-counter drugs, and recreational drug use if any): _____

II. SURGERIES:
List all previous operations, year, and type of anesthesia.
(gen, local, spinal) _____

Do you have any **MEDICATION ALLERGIES?** Yes No
If "YES" please list: _____

Do you have any **FOOD ALLERGIES?** Yes No
If "YES" please list _____

Do you have **SLEEP APNEA?** Yes No

Are you allergic to **LATEX** or **RUBBER PRODUCTS?** Yes No

List any other hospitalizations with reasons and approximate dates and any chronic illness(es) or condition(s): _____

Primary Care Physician: _____ Phone: _____
Specialty Physician: _____ Phone: _____

III. HEIGHT:_____ **WEIGHT:**_____

IV. HAVE YOU HAD:	**PLEASE CIRCLE** (IF YES, PLEASE EXPLAIN)		
1. High Blood Pressure	Yes	No	
2. Heart trouble or Heart Attack	Yes	No	
a) Chest pain or Angina	Yes	No	
b) Irregular Heart Beat	Yes	No	
c) Congestive Heart Failure	Yes	No	
d) Abnormal electrocardiogram	Yes	No	
3. Gastric Esophageal Reflux, Hiatal Hernia, Ulcers:	Yes	No	
4. A recent cold, cough or sore throat	Yes	No	
5. Asthma, Emphysema, bronchitis	Yes	No	
or breathing problem	Yes	No	
6. Abnormal chest x-ray	Yes	No	
7. Diabetes	Yes	No	
8. Yellow jaundice or hepatitis	Yes	No	
9. Kidney Disease	Yes	No	
10. Abnormal bleeding problems	Yes	No	
11. Stroke, numbness or weakness	Yes	No	
12. Epilepsy or convulsive seizures	Yes	No	
13. Broken bones of back, neck or face	Yes	No	
14. Back trouble	Yes	No	
15. Unusual muscle problems or diseases	Yes	No	
16. Unexplained fevers or heatstrokes	Yes	No	
17. Bad reactions to anesthetics	Yes	No	
18. Any relative with bad reaction to anesthetics	Yes	No	
19. Psychological or emotional problems	Yes	No	
20. Any problems with motion sickness	Yes	No	
V. DO YOU:			
1. Wear Dentures	Yes	No	
2. Have caps on teeth	Yes	No	
3. Drink alcohol (How much per day)	Yes	No	
4. Smoke (How much per day)	Yes	No	
5. Exercise or have strenuous activity	Yes	No	
6. Have physical limitations	Yes	No	
VI. Female (If applicable) Is there any possibility you could be pregnant?	Yes	No	
VII. Are you aware there is a risk with **EVERY** Anesthetic given	Yes	No	

VIII. Do you have questions or concerns you would like to discuss with your Anesthesiologist? _____

Phone number you can be reached at the evening before surgery: (_____) _____ Email Address _____

Signed by Patient _____ Date _____

Questionnaire and Pre-Op teaching done by _____ Date _____

Print Patient Name _____

rev12/14

MEMORIALCARE®
SURGICAL CENTER

Saddleback Memorial
An Affiliate of SCA

PATIENT INFORMATION QUESTIONNAIRE

DATE OF SURGERY _____ NAME OF SURGEON _____

PATIENT NAME _____
Last First Middle Initial

EMAIL ADDRESS _____

NAME OF PARENT (If patient is a minor) _____

DATE OF BIRTH ____/____/____ SEX _____ MARITAL STATUS (Please Circle) S M D W

SOCIAL SECURITY # _____ DRIVERS LICENSE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # ( ) _____ WORK PHONE # ( ) _____

CELL/OTHER PHONE # ( ) _____ PARENT PHONE # ( ) _____

NAME OF EMPLOYER _____ OCCUPATION _____

DATE OF INJURY _____ IS THIS YOUR FIRST TIME AT OUR FACILITY? Y N

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE# _____

HAVE YOU HAD SURGERY AT THIS FACILITY WITHIN THE LAST 12 MONTHS? Y N

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE CARRIER

ID# OF INSURED

INSURANCE CLAIM ADDRESS

NAME OF INSURED

CITY STATE ZIP CODE

BIRTH DATE OF INSURED (if other than self)

INSURANCE CO. CUSTOMER SERVICE PHONE#

GROUP NAME

INSURANCE CO. PRE-CERTIFICATION PHONE#

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE CARRIER

ID# OF INSURED

INSURANCE CLAIM ADDRESS

NAME OF INSURED

CITY STATE ZIP CODE

BIRTH DATE OF INSURED (if other than self)

INSURANCE CO. CUSTOMER SERVICE PHONE#

GROUP NAME

MEMORIALCARE
SURGICAL CENTER

Saddleback Memorial
An Affiliate of SCA

24411 Health Center Drive, Suite 104
Laguna Hills, CA 92653
949-458-5600

INSURANCE INFORMATION

Prior to your surgery/procedure, you will receive a call from a representative of the business office who will review your insurance coverage and any estimated subsequent financial responsibilities to the surgery center. During this conversation, you will be apprised of any co-pays, deductibles and co-insurance responsibilities based on your specific insurance plan coverage.

- ***This estimate is based on the procedure (s) your surgeon has scheduled and your insurance plan.***
- ***It is important to know that this is only an estimate. Sometimes the surgeon needs to do more or maybe even less during the procedure than was originally scheduled. These changes may affect your final billing and financial responsibility.***
- ***Payment of co-pays, co-insurance and deductibles are due upon your check in to the surgery center on the day of surgery, unless prior payment arrangements have been made.***

Please be aware that enrollment in an insurance plan ***does not guarantee payment*** by your insurance company. Therefore, we advise that you contact your insurance company before surgery to verify benefits and coverage.

A letter and/or statement of charges will be sent to the responsible party indicating any outstanding balance. All balances 60 days past due will be subject to a 1.5% monthly finance charge. Delinquent balances (unpaid balances after 90 days) may be referred to an outside collection agency.

Because there are several healthcare practitioners providing service to you, you can expect to receive separate bills from each of these providers. These providers can include but are not limited to the following:

- MemorialCare Surgical Center Saddleback Memorial (Facility fee)
- Surgeon Fee
- Anesthesiologist Fee
- Pathology Fee (if specimen is sent to the lab by your surgeon)

If you require any additional information, please feel free to call 949-458-5600. Any one of our business office staff will be happy to assist you.

MEMORIALCARE®
SURGICAL CENTER

Saddleback Memorial
An Affiliate of SCA

24411 Health Center Drive, Suite 104
Laguna Hills, CA 92653
949-458-5600

PAYMENT POLICY

It is the policy of MemorialCare Surgical Center Saddleback Memorial to receive payment in full at the time of admission unless other arrangements have been made in advance.

If you would like our office to bill your insurance, please provide a copy of the insurance card(s), proof of identity and completed forms of information which are required and must be presented upon admission.

Please be aware that enrollment in an insurance plan **does not** guarantee payment by your insurance company. Therefore, we advise that you contact your insurance company to verify your benefits and coverage for outpatient surgery before the date of surgery. MemorialCare Surgical Center Saddleback Memorial **does not** assume responsibility for verification of insurance benefits and coverage.

Co-payments and deductibles are due at the time of admission. Any portion of the balance not paid by the insurance is the responsibility of the patient or guarantor.

A letter and or a statement of charges will be sent to the responsible party indicating any outstanding balance. All balances 60 days past due will be subject to a 1.5% monthly finance charge. Delinquent balances (unpaid balances after 90 days) may be referred to an outside agency for collection.

I have read the above policy and understand that I am financially responsible for paying for services rendered at MemorialCare Surgical Center Saddleback Memorial.

_____ _____
Signature of Patient/Guarantor Date

_____
Print Name

MEMORIALCARE SURGICAL CENTER

Saddleback Memorial
An Affiliate of SCA

Patient Rights and Responsibilities

SCA observes and respects a patient's rights and responsibilities without regard to age, race, color, sex, gender indentity, national origin, religion, culture, physical or mental disability, personal values or belief systems.

You have the right to:

- Considerate, respectful and dignified care and respect for personal values, beliefs and preferences.
- Access to treatment without regard to race, ethnicity, national origin, color, creed/religion, sex, gender identity, age, mental disability, or physical disability. Any treatment determinations based on a person's physical status or diagnosis will be made on the basis of medical evidence and treatment capability.
- Respect of personal privacy.
- Receive care in a safe and secure environment.
- Exercise your rights without being subjected to discrimination or reprisal.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers and, if applicable, the lack of malpratice coverage.
- Expect the center to disclose, when applicable, physician financial interests or ownership in the facility.
- Receive assistance when requesting a change in primary or specialty physicians, dentists or anesthesia providers if other qualified physicians, dentists or anesthesia providers are available.
- Receive information about health status, diagnosis, the expected prognosis and expected outcomes of care, interms that can be understood, before a treatment or a procedure is performed.
- Receive information about unanticipated outcomes of care.
- Receive information from the physician about any proposed treatment or procedure as needed in order to give or withhold informed consent.
- Participate in decisions about the care, treatment or services planned and to refuse care, treatment or services, in accordance with law and regulation.
- Be informed, or when appropriate, your representative be informed (as allowed under state law) of your rights in advance of furnishing or discontinuing patient care whenever possible.
- Receive information in a manner tailored to your level of understanding, including provision of interpretative assistance or assistive devices.
- Have family be involved in care, treatment, or services decisions to the extent permitted by you or your surrogate decision maker, in accordance with laws and regulations.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films or other images at any time.
- Be informed of and permit or refuse any human experimentation or other research/educational projects affecting care or treatment.
- Confidentiality of all information pertaining to care and stay in the facility, including medical records and, except as required by law,the right to approve or refuse the release of your medical records.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Have an advance directive, such as a living will or durable power of attorney for healthcare, and be informed as to the facility's policy regarding advance directives/living will. Expect the facility to provide the state's official advance directive form if requested and where applicable.
- Obtain information concerning fees for services rendered and the facility's payment policies.
- Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Be free from all forms of abuse or harassment.
- Access to language assistance service, free of charge, by a qualified interpreter for individuals with limited English proficiency or individuals with a disability.
- Expect the facility to establish aprocess for prompt resolution of patients' grievances and to inform each patient whom to contact to file a grievance. Grievances/complaints and suggestions regarding treament or care that is (or fails to be) furnished may be expressed at any time. Grievances may be lodged with the state agency directly using the contact information provided below.

If a patient is adjudged incompetent under applicable State Laws by a court of proper jurisdiction, the rights of the patient will be exercised by the person appointed under the State Law to act on the patient's behalf.

If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State Law may exercise the patient's rights to the extent allowed by State law.

You are responsible for:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the center.
- Identifying any patient safety concerns.
- Observing prescribed rules of the center during your stay and treatment.
- Providing a responsible adult to transport you home from the center and remain with you for 24 hours if required by your provider.
- Reporting whether you clearly understand the planned course of treatment and what is expected of you and asking questions when you do not understand your care, treatment, or service or what you are expected to do.
- Keeping appointments and, when unable to do so for any reason, notifying the center and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications-including over-the-counter products and dietary supplements,and any allergies or sensitivities, unexpected changes in your condition or any other patient health matters.
- Promptly fulfilling your financial obligations to the facility, including charges not covered by insurance.
- Payment to facility for copies of the medical records you may request.
- Informing your providers about any living will, medical power of attorney, or other advance directives that could affect your care.

You may contact the following entities to express any concerns, complaints or grievances you may have:

FACILITY	Steve Hildreth, CEO Administrator 949-458-5600
STATE AGENCY	California Department of Public Health Center for Health Care Quality (CHCQ) Licensing and Certification Division P.O. Box 997377 MS 3000 Sacramento, CA 95899 Complaints (800) 236-9747 General Information (916) 558-1784
MEDICARE	Office of the Medicare Beneficiary Ombudsman: www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
OFFICE OF CIVIL RIGHTS	US Department of Health and Human Services Office of Civil Rights 200 Independence Avenue SW, Room 509F, HHH Building Washington D.C. 20201 800-368-1019; (800) 537-7697 (TDD) Internet address: https//ocrportal.hhs.gov/ocr/portal/lobby.jst
ACCREDITING ENTITY	AAAHC (Accreditation Association for Ambulatory Health Care) 5250 Old Orchard Road, Suite 200 Skokie, IL 60077 847-853-6060 www.aaahc.org

To care for our patients, serve our physicians, and improve healthcare in America

MEMORIALCARE
SURGICAL CENTER

Saddleback Memorial
An Affiliate of SCA

24411 Health Center Drive, Suite 104
Laguna Hills, CA 92653
949-458-5600

INFORMATION REGARDING ADVANCE DIRECTIVES

Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion.

A ***living will*** communicates your wishes in regard to how you feel about care intended to sustain life. You can accept or refuse medical care.

A durable power of attorney for healthcare is a document that names your health care proxy. Your proxy is someone you trust to make healthcare decisions if you are unable to do so.

While all these documents play a very important role as to how health care decisions are made on your behalf, it is the policy of MemorialCare Surgical Center Saddleback Memorial that we do not implement the elements or instructions of an advance directive, living will, or health care proxy on basis of conscience.

If you have an Advance Directive, please bring it with you on the day of surgery. We will place it in your medical record for reference in the unlikely event you are transferred to the hospital.

If you do not have an Advance Directive and would like more information, please contact us and we will be happy to help you. Or you can log on to *www.caringinfo.org.*