Below is information regarding your up-coming appointment with CHOC Children's Specialists Division of Pediatric Surgery. If you are unable to keep your appointment, we would appreciate a phone call at least 24 hours ahead of time.

Patient Name: ____________________________  Appointment Time: _______: AM / PM

Appointment Date: _______/ _______/ ________  Check In Time: _______: AM / PM

Physician:
☐ David L. Gibbs, MD, FACS, FAAP  ☐ Mustafa H. Kabeer, MD, FACS, FAAP
☐ Troy M. Reyna, MD, FACS, FAAP

Location:
☐ Orange Office  ☐ Mission Viejo Office
☐ Corona Office  ☐ Newport Office

Appointmen Day:
☐ Monday  ☐ Tuesday  ☐ Wednesday  ☐ Thursday

What to bring to your appointment:

* Patient's Insurance Card
* Photo ID for person bringing patient to appointment and/or responsible party
* Completed Patient Demographics Form - Signed and Dated
* Completed Patient Health History Record Form - Signed and Dated
* Co-Payment if applicable. Co-Payments are due at time of appointment.

(We accept cash, personal checks, MC, Visa, American Express and Discover)

Important - Please Read:
If someone other than the patient's parent or legal guardian will be bringing the patient to their appointment, please call our office. We will need documentation from the parent/legal guardian giving permission. Please be aware that the person bringing the patient must be at least 18 yrs. of age.

See reverse side and/or attachment for maps and directions:

Orange Office:
505 S. Main Street, Suite 225
Orange, CA 92868
(#13 on CHOC campus map, CHOC Commerce Tower)

Orange Office Parking:
Bring Parking ticket to office. We can validate your parking ticket for 1 hour. $1 for each addl. 30 mins.

Corona Office:
260 E. Ontario Ave, Suite 204
Corona, CA 92882
(Shared space with Pediatrician - Dr. Cresencia Banzuela)
Parking is an open lot with no fees.

Mission Viejo Office:
27800 Medical Center Road, Suite 138
Mission Viejo, CA 92691

Mission Office Parking:
We DO NOT validate parking. Please be prepared to pay any parking fees.

Newport Office:
500 Superior Avenue
Suite 140
Newport Beach, CA 92663
CHOC Children's Specialty Clinic
Parking is an open lot with no fees.
**Directions to Orange Office**

**From 5 Frwy. Going South**
- 5 South to 22 East
- Exit Main Street Turn Right
- Turn Right onto Main Street
- Turn right at La Veta (2nd Light)
- Turn Right at 1st driveway

**From 5 Frwy. Going North**
- Exit main Street North, turn Right
- Turn Right at La Veta
- Turn Right at 1st driveway

**From 22 Frwy. Going East**
- Exit Main Street turn Right
- (Town and Country)
- Turn Right onto Main Street
- Turn right at La Veta (2nd Light)
- Turn Right at 1st driveway

**From 22 Frwy. Going West**
- Exit Main Street turn Left
- Turn Left into 4th driveway
- (last driveway before light at Main Street)

**Directions to Mission Office**

**From 5 Frwy. Going South**
- Exit Crown Valley Parkway turn Left
- Turn Right at Medical Center Road
- Turn Left into 3rd Driveway

**From 5 Frwy. Going North**
- Exit Crown Valley Parkway turn Right
- Turn Right at Medical Center Road
- Turn Left into 3rd Driveway

**Directions to Corona Office**

**From 91 Frwy.**
- Exit Main Street (go South)
- Turn Left at Ontario Avenue
- Turn Right into 2nd Driveway
- (Chronic Tacos and Timmy's Diner)

**From 15 Frwy.**
- Exit Magnolia (go West)
- Turn Right at Ontario Avenue
- Make a U Turn at Main Street
- Turn Right into 2nd Driveway (Chronic Tacos and Timmy's Diner)

**This is a satellite office. We are sharing the office space of Dr. Cresencia D. Banzuela. You will not see any signs with CHOC, Dr. Kabeer's name or Pediatric Surgery.**

**Directions to Newport Beach Office**

**From Pacific Coast Highway**
- Turn North onto Superior Avenue
- Turn Right at Hoag Health Center (Light)
- Building will be on your Right

**From 55 Frwy. / Newport Blvd. Going South**
- Continue until freeway ends and becomes Newport Blvd.
- Turn Right at Hospital Road
- Turn Right at Placentia Road
- Turn Right at Superior Avenue
- Turn Right at Hoag Health Center (Light)
- Building will be on your Right

**This is a satellite office. We are in the CHOC Children's Specialty Clinic office.**
505 S. Main Street, Suite 225
Orange, CA 92868
#13 on above campus map

27800 Medical Center Road, Suite 138
Mission Viejo, CA 92691
Next to Pharmacy - Medical Office Building 2

260 E. Ontario Avenue, Suite 204
Corona, CA 92882
Office of Crescencia Banzuela, MD - Pediatrician
(Reminder: you will not see a sign with Dr. Kabeer's name)
# Patient Demographics

**Name:**
- First
- Middle
- Last

**Birth Date:** / / 

**Male** □ **Female** □ **Age:** 

**Address:**

**City:**
- State:
- Zip:

**Home Phone:** ( )

**Social Security #:** - - 

**Primary Care Physician:**
- First
- Last
- Phone: ( )

**Referring Physician:**
- First
- Last
- Phone: ( )

**Name:**
- First
- Middle
- Last

**Birth Date:** / / 

**Marital Status:** Married / Single / Divorced

**Address:**

**City:**
- State:
- Zip:

**Home Phone:** ( )

**Social Security #:** - - 

**Cell Phone:** ( )

**Work Phone:** ( )

**Email Address:**
- (used for communication purposes with office only)

**Employer / Occupation:**

**Name:**
- First
- Middle
- Last

**Birth Date:** / / 

**Marital Status:** Married / Single / Divorced

**Address:**

**City:**
- State:
- Zip:

**Home Phone:** ( )

**Social Security #:** - - 

**Cell Phone:** ( )

**Work Phone:** ( )

**Email Address:**
- (used for communication purposes with office only)

**Employer / Occupation:**

**Name:**
- First
- Middle
- Last

**Birth Date:** / / 

**Marital Status:** Married / Single / Divorced

**Address:**

**City:**
- State:
- Zip:

**Home Phone:** ( )

**Social Security #:** - - 

**Cell Phone:** ( )

**Work Phone:** ( )

**Email Address:**
- (used for communication purposes with office only)

**Employer / Occupation:**

**Name:**
- First
- Middle
- Last

**Birth Date:** / / 

**Relationship to Patient:**
- Cell Phone: ( )

**Primary Insurance:**
- HMO □
- PPO □

**Medical Group:**

**ID #:**

**Group #:**

**Subscriber's Name:**

**Relationship to Patient:**

---

**Insurance Eligibility Guarantee:** I understand that if the above health insurance information provided by myself is not true or if I am not eligible under the terms of the Medical Subscriber Agreement, I am responsible for any and all charges for services rendered. Also if I am not eligible for health insurance coverage, I agree to pay in full for all services rendered within thirty (30) days of receiving a bill from the provider's office.

**Release of Information/Assignment of Benefits:** I hereby authorize the release of any medical information necessary to process insurance claims and authorize payment of benefits to the attending physician.

---

**Signature of Responsible Person**

**Relationship to Patient**

**Date**

updated: 1/14/13
# PEDIATRIC SURGERY

## HEALTH HISTORY RECORD

**(TO BE COMPLETED BY PARENT/LEGAL GUARDIAN)**

<table>
<thead>
<tr>
<th><strong>PATIENT</strong></th>
<th><strong>Birth Date:</strong> / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>First</td>
<td>Middle</td>
</tr>
<tr>
<td>Birth Weight:</td>
<td>Current Weight:</td>
</tr>
<tr>
<td>Referring Physician:</td>
<td>Primary Care Physician:</td>
</tr>
</tbody>
</table>

**What is the reason for today's visit (in your own words)?**

---

<table>
<thead>
<tr>
<th><strong>NEONATAL HISTORY</strong></th>
<th><strong>NO</strong></th>
<th><strong>YES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ □ Prematurity (gestational age - ______ weeks)</td>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>□ □ Respiratory Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ □ Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ □ Feeding Disorders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**List any significant medical problems:**

---

**Previous Surgeries:** □ NO □ YES

<table>
<thead>
<tr>
<th>Date:</th>
<th>Surgery Performed:</th>
<th>Where Performed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Problems with Anesthesia:** □ □

**Bleeding Disorders:** □ □

**Allergies to Medications:** □ □

**Other Allergies (latex, etc.):** □ □

**List any prescription and non-prescription medications your child is taking:**

---

**Any other information or concerns you would like your physician to be aware of:** □ NO □ YES

---

*I confirm that the above information is true and correct to the best of my knowledge (Parent/Guardian please sign below.)*

Signature of Responsible Person: __________________________ Relationship to Patient: __________________________ Date: __________________________

*updated: 6/30/12*