



## PATIENT REGISTRATION / INFORMATION SHEET

Name (Last, First, Middle Initial): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex at Birth: ☐ Male ☐ Female Marital Status: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Email Address\*: \_\_\_\_\_

*\*By providing your email address, you are choosing to receive email communication from Hoag Medical Group and its affiliates.*

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spoken Language: \_\_\_\_\_ Written Language: \_\_\_\_\_

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American

☐ Native Hawaiian and other Pacific Islander ☐ Other ☐ Unknown ☐ Decline to answer

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline to answer

Religious Preference (optional): \_\_\_\_\_

Employment Status: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Retirement (if applicable): \_\_\_\_\_ Spouse's Date of Retirement (for Medicare patients): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Insurance: ☐ HMO ☐ POS/PPO ☐ Medicare ☐ Cash ☐ Other: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy/ID#: \_\_\_\_\_

Secondary Insurance: ☐ HMO ☐ POS/PPO ☐ Medicare ☐ Cash ☐ Other: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy/ID#: \_\_\_\_\_

Primary Insurance Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employment Status: \_\_\_\_\_ Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Other Treating Physician: \_\_\_\_\_

Why did you select Hoag?

- ☐ New to the area ☐ Switching from a previous provider to a Hoag provider  
☐ New Insurance ☐ Existing Hoag Physician Partners/Hoag Medical Group patient

What is the primary reason for Primary Care Physician change?

- ☐ Primary Care Physician availability (prior Primary Care Physician not available/ in-network)  
☐ Primary Care Physician location/convenience  
☐ Primary Care Physician ability to meet needs/experience  
☐ Access to Hoag Services  
☐ No prior relationship with Primary Care Physician  
☐ No change – need to be reconnected with Primary Care Physician

Patient/Legal Representative: \_\_\_\_\_ Date/Time: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

Print Name—Legal Representative: \_\_\_\_\_

### REGISTRATION FORM

Form# 8019  
Encounter Level

Rev 07/03/24

PATIENT LABEL



[1219]

# HEALTH HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Previous Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Current Specialists:

1) Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2) Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Note: If you are currently seeing more specialists than the space above allows, please list the additional specialists on the back of this form.

**Allergies:** Any known drug allergies? ☐ Yes ☐ No

Please list all allergies including food, medications and environmental and reaction.

**Do you currently take any medications on a regular basis?** ☐ Yes ☐ No

If yes, please list any medications that you currently take on a regular basis (include non-prescriptions).

| Medication | Dosage | Frequency |
|------------|--------|-----------|
|            |        |           |
|            |        |           |
|            |        |           |
|            |        |           |

| Medication | Dosage | Frequency |
|------------|--------|-----------|
|            |        |           |
|            |        |           |
|            |        |           |
|            |        |           |

Note: If you are currently taking more medications than the space above allows, please list the additional medications on the back of this form.

## MEDICAL HISTORY

**Illness and Conditions** - Do you have or have you ever had any of the following:

- Year: \_\_\_\_\_
- ☐ Alcoholism \_\_\_\_\_
  - ☐ Anxiety \_\_\_\_\_
  - ☐ Anemia \_\_\_\_\_
  - ☐ Arthritis \_\_\_\_\_
  - ☐ Asthma \_\_\_\_\_
  - ☐ Bleeding Problems \_\_\_\_\_
  - ☐ Birth Defects \_\_\_\_\_
  - ☐ Cancer, Type: \_\_\_\_\_
  - ☐ Colitis \_\_\_\_\_
  - ☐ Concussion \_\_\_\_\_
  - ☐ Depression/Nervous Breakdown \_\_\_\_\_
  - ☐ Diabetes \_\_\_\_\_
  - ☐ Emphysema \_\_\_\_\_

Have you had any past medical problems?

☐ Yes ☐ No If yes, list below:

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Have you had any previous surgeries or hospitalizations?

☐ Yes ☐ No If yes, list details and date below:

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Year:

|                                                       |       |
|-------------------------------------------------------|-------|
| <input type="checkbox"/> GERD/Heartburn/Reflux        | _____ |
| <input type="checkbox"/> Gout                         | _____ |
| <input type="checkbox"/> Heart Attack/Heart Disease   | _____ |
| <input type="checkbox"/> High Blood Pressure          | _____ |
| <input type="checkbox"/> High Cholesterol             | _____ |
| <input type="checkbox"/> Kidney Disease               | _____ |
| <input type="checkbox"/> Lupus                        | _____ |
| <input type="checkbox"/> Liver Disease/Hepatitis      | _____ |
| <input type="checkbox"/> Migraine Headache            | _____ |
| <input type="checkbox"/> Mitral Valve Prolapse/Murmur | _____ |
| <input type="checkbox"/> Osteoporosis                 | _____ |
| <input type="checkbox"/> Prostate Enlargement (BPH)   | _____ |
| <input type="checkbox"/> Rheumatoid Arthritis         | _____ |
| <input type="checkbox"/> Seizure Disorder             | _____ |
| <input type="checkbox"/> Sexually Transmitted Disease | _____ |
| <input type="checkbox"/> Skin Problems                | _____ |
| <input type="checkbox"/> Stroke                       | _____ |
| <input type="checkbox"/> Thyroid Disease              | _____ |
| <input type="checkbox"/> Tuberculosis                 | _____ |
| <input type="checkbox"/> Other: _____                 | _____ |

## Childhood Diseases

☐ Chicken Pox \_\_\_\_\_  
☐ Measles \_\_\_\_\_  
☐ Mumps \_\_\_\_\_  
☐ Polio \_\_\_\_\_  
☐ Other: \_\_\_\_\_

### Gynecological History (women only)

Last Menstrual Period \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Have you ever had an abnormal pap smear? \_\_\_\_\_

Have you had a hysterectomy? \_\_\_\_\_

Have your ovaries been removed? \_\_\_\_\_

## Sexual History

Do you have sex with: ☐ Men ☐ Women ☐ Both  
Have you had an HIV Test? ☐ Yes ☐ No  
Do you use condoms for sexual intercourse? ☐ Yes ☐ No

## FAMILY HISTORY

Do you have any family history of serious illness? ☐ Yes ☐ No

If yes, list below:

|                        | Mother                   | Father                   | Grandparent              |
|------------------------|--------------------------|--------------------------|--------------------------|
| Alcoholism             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Problems      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer, Type: _____    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Illness/Suicide | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|          | Living Age | Deceased Age at Death and Cause |
|----------|------------|---------------------------------|
| Father   |            |                                 |
| Mother   |            |                                 |
| Brother  |            |                                 |
|          |            |                                 |
|          |            |                                 |
|          |            |                                 |
| Sister   |            |                                 |
|          |            |                                 |
|          |            |                                 |
| Son      |            |                                 |
|          |            |                                 |
|          |            |                                 |
| Daughter |            |                                 |
|          |            |                                 |
|          |            |                                 |



## HEALTH MAINTENANCE

When did you last have any of the following?

|                |       |                     |       |
|----------------|-------|---------------------|-------|
| Diabetes Check | _____ | Pap Smear           | _____ |
| Prostate Check | _____ | Cholesterol Check   | _____ |
| Colonoscopy    | _____ | Cardiac Stress Test | _____ |
| Mammogram      | _____ | Bone Density        | _____ |

List year of Last Vaccinations:

|                 |       |              |       |
|-----------------|-------|--------------|-------|
| Tetanus (TD)    | _____ | Hepatitis A  | _____ |
| Influenza (Flu) | _____ | Hepatitis B  | _____ |
| Pneumonia       | _____ | HPV          | _____ |
| Shingles (VZV)  | _____ | TB Skin Test | _____ |

## SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Co-habiting ☐ Separated ☐ Divorced ☐ Widowed

Do you have children/dependents at home? ☐ Yes ☐ No How many? \_\_\_\_\_

Are you employed? ☐ Yes ☐ No Occupation: \_\_\_\_\_

What is your highest level of education? ☐ High School ☐ College ☐ Graduate School

Do you or have you ever smoked or chewed tobacco? ☐ Yes ☐ No When? \_\_\_\_\_ Quit Date: \_\_\_\_\_  
☐ Packs/☐ Cans/☐ Bags per day: \_\_\_\_\_ / years: \_\_\_\_\_

Do you or have you ever used recreational drugs? ☐ Yes ☐ No Type: \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink alcohol? ☐ Yes ☐ No Type: \_\_\_\_\_ How often? \_\_\_\_\_  
How much per day? \_\_\_\_\_ / \_\_\_\_\_ years

Have you ever been exposed to toxic substances? ☐ Yes ☐ No Type: \_\_\_\_\_ What kind? \_\_\_\_\_

Do you drink caffeine? ☐ Yes ☐ No Type: \_\_\_\_\_ How often? \_\_\_\_\_

Do you exercise? ☐ Yes ☐ No Type: \_\_\_\_\_ How often? \_\_\_\_\_

Do you wear a seatbelt? ☐ Yes ☐ No

Do you use car seats for your children if under 60 lbs.? ☐ Yes ☐ No

Do you have a living will or advance directives? ☐ Yes ☐ No

Patient/Legal Representative Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

Print Name (Legal Representative): \_\_\_\_\_

### PATIENT HEALTH HISTORY

Form# 8020

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Rev 06/03/24

PATIENT LABEL



## AUTHORIZATION TO SHARE PATIENT INFORMATION

Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Date of Birth: \_\_\_\_\_

### Phone Messages

Do you give permission for Hoag Memorial Hospital Presbyterian and its affiliates and affiliated providers ("Hoag") to call your primary and mobile phone numbers on file and leave **detailed** messages regarding your care, results, appointment/health screening reminders and other health care messages?

☐ Yes ☐ No

### Personal Health Representative(s)

Is there someone else who Hoag can leave **detailed** messages with, verbally **share health information**, and/or **discuss plan of care**?

☐ Yes ☐ No If yes, please provide:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Requests for medical records require separate authorization. You may do so via Hoag's patient portal: Hoag Connect MyChart [www.hoagconnect.org](http://www.hoagconnect.org), or download and complete an authorization form at [www.hoag.org](http://www.hoag.org).

The most current Authorization to Share Patient Information is the active authorization and remains in effect until a new Authorization to Share Patient Information is completed.

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

If signed by other than patient, indicate relationship: \_\_\_\_\_

Print Name – Legal Representative: \_\_\_\_\_

AUTHORIZATION TO SHARE PATIENT INFORMATION

Form# 8006

Rev 07/03/24



[5671]

PATIENT LABEL



## CONDITIONS OF TREATMENT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

LAST

FIRST

MIDDLE

### **Consent to Treatment**

I hereby consent to all health care treatment and procedures provided by Hoag, Hoag affiliates and Hoag affiliated providers (collectively "Hoag"), its physicians, clinicians, and other personnel. Such treatment and procedures may include diagnostic, therapeutic, imaging, and laboratory services.

### **Financial Responsibility**

I hereby assign and authorize direct payment to Hoag of any insurance benefits otherwise payable to me or on my behalf for the services rendered. I understand that I am financially responsible for charges not paid according to this assignment.

I hereby attest that the insurance information provided to Hoag and its providers is accurate, and that I am currently eligible for insurance coverage. I understand that I am responsible for knowing my benefits/ coverage and acknowledge that tests ordered by my physician may NOT be covered by my insurance company.

I hereby authorize the release of all information to other physicians and insurance carriers for the purpose of payment for medical services, and further treatment of care by another physician. I further agree that a photocopy of this form shall be as valid as the original.

Payment is due at the time services are rendered. All charges are my direct responsibility. Hoag cannot render medical services on the assumption that the charges will be paid by my insurance company. If Hoag has problems collecting payment from me, in addition to interest, Hoag may also add attorney's fees, collection agency costs and any related fees to my bill.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

### **Communication**

I hereby consent to receiving messages as indicated above from Hoag. These parties may use the provided information to contact me by e-mail, live agent, voice mail, text message or pre-recorded message, including by using an auto-dialer or other computer assisted technology, or by any other electronic communication for purposes that include appointment and follow-up health care reminders, pre-registration, surveys, prescription information, health-related products or services that may be of interest, my account(s), assignment of benefits, and financial responsibility. I understand that depending on my phone plan, I could be charged for these calls or text messages. I also understand that providing this contact information and consent are not conditions to receiving health care services. With respect to text messages, I understand that I can opt-out at any time by replying "STOP" to the text message from my mobile device.

### **Patient Portal**

Hoag utilizes a Patient Portal, which allows me to electronically access my medical information. By signing this form, I hereby request and agree that my medical information and laboratory test results may be uploaded to the Patient Portal, so that I may access them electronically as part of my clinical health record. I understand that uploading of test results for a positive HIV test, hepatitis, drug abuse, or test results related to routinely processed tissues, or imaging scans that reveal a new or recurrent malignancy may be delayed.

**By signing below, I acknowledge that I have carefully read, understand, and agree to the terms of this Conditions of Treatment.**

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

Print Name (Legal Representative): \_\_\_\_\_

#### CONDITIONS OF TREATMENT

Form# 8035

Rev 07/01/25



[5672]

PATIENT LABEL



## NOTICE OF OPEN PAYMENTS DATABASE

In compliance with Assembly Bill No. 1278, which was filed by the Secretary of State on September 29, 2022, we would like to make you aware of the Open Payments database.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

The Open Payments database was developed as part of the federal Physician Payments Sunshine Act which requires that detailed information about payments or items of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals, be reported and made available to the public.

By signing below, you are acknowledging receipt of this information.

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ A.M./P.M.

If signed by other than patient, indicate relationship: \_\_\_\_\_

Print Name (Legal Representative): \_\_\_\_\_

### INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

- ☐ Patient or Legal Representative received Notice of Open Payments Database but refused to sign.
- ☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Open Payments Database.
- ☐ Other: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Hoag Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This form is not for use in the Hospital. For questions on use or applicability, please contact Corporate Compliance at (800) 441-1727.

#### NOTICE OF OPEN PAYMENTS DATABASE

Form # 8121  
Patient Level

Rev 06/03/24

Original – Chart

Copy - Patient

PATIENT LABEL



[1336]



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Hoag Memorial Hospital Presbyterian and its affiliates and affiliated providers ("Hoag") may share my health information for treatment, billing and healthcare operations. I have been provided a copy of Hoag's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Hoag has the right to change this notice at any time. I may obtain an additional copy by visiting the website at [www.hoag.org](http://www.hoag.org) or contacting the provider's registration desk.

I acknowledge receipt of the Notice of Privacy Practices of Hoag Memorial Hospital Presbyterian.

Patient's Name: \_\_\_\_\_

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

Print Name (Legal Representative): \_\_\_\_\_

### INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

- ☐ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt.
- ☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices.
- ☐ Other: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Hoag Staff Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

