# PATIENT REGISTRATION / INFORMATION SHEET

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Gender: ☐ Male ☐ Female Marital Status: _____
Social Security Number: _____ Email Address*: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Primary Language: _____
Race: ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Unknown
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Religious Preference (optional): _____
*By providing your email address, you are electing to receive email communication from Hoag Medical Group and its affiliates.

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: _____

I hereby give my permission to contact the above mentioned individual if I cannot be reached. I further give my permission for any treating physician or physician's representative to speak with this person regarding me or my medical condition including but not limited to lab/pathology/diagnostic test results. ☐ Yes ☐ No

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: _____

Patient/Legal Representative: _____ Date/Time: _____
If signed by other than patient, indicate relationship: _____
Print Name – Legal Representative: _____

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# AUTHORIZATION TO SHARE PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____

## Phone Messages

Is there a phone number where the Hoag entity selected above and affiliates can call and leave detailed messages regarding your care, appointment/health screening reminders and other health care messages?

☐ Yes ☐ No If yes, please provide phone number: _____

## Text Messages

Do you wish to receive appointment/health screening reminders and other health care messages via text?

☐ Yes ☐ No

If yes, please provide preferred phone number to receive text messages: _____

## E-Mail

Do you wish to receive appointment/health screening reminder and other health care messages via e-mail?

☐ Yes ☐ No

If yes, please provide preferred e-mail address: _____

## Additional Contact

Is there someone else who the Hoag entity selected above and affiliates can leave detailed messages with and share your patient information?

☐ Yes ☐ No If yes, please provide:

Name: _____ Relationship to Patient: _____

Phone Number: _____

I hereby consent to receiving messages as indicated above from the Hoag entity selected above and affiliates. 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.

The Authorization to Share Patient Information remains in effect until a request to withdraw from this form is submitted in writing by the patient.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____AM/PM
If signed by other than patient, indicate relationship: _____
Print Name – Legal Representative: _____

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# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that the Hoag entity selected above and affiliates may share my health information for treatment, billing and healthcare operations. I have been provided a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that the Hoag entity selected above and affiliates has the right to change this notice at any time. I may obtain an additional copy by contacting my provider's office selected above.

I acknowledge receipt of the Notice of Privacy Practices:

Patient Name: _____

Signature: _____ Date: _____
PATIENT / LEGAL REPRESENTATIVE

If signed by other than patient, indicate relationship to patient: _____

## INABILITY TO OBTAIN ACKNOWLEDGMENT

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

Reasons why the acknowledgment was not obtained:

☐ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgment of Receipt

☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices

☐ Other: _____

Patient Name: _____

Staff Signature: _____ Date: _____

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# 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:

_____

_____

_____

_____

_____

Have you had any previous surgeries or hospitalizations?

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

_____

_____

_____

_____

_____

_____



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

| Childhood Diseases | Year: |
|---|---|
| ☐ 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 | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ |
| Cancer, Type: _____ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Mental Illness/Suicide | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ |
| Thyroid | ☐ | ☐ | ☐ |

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



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## 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 Signature: _____ Date/Time: _____



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# HEALTH INFORMATION EXCHANGE AUTHORIZATION

The Hoag entity selected above and affiliates participates in a Health Information Exchange called Care Everywhere. Care Everywhere is aimed at improving the coordination and quality of health care services you receive by providing your health care providers with information regarding your current and past health. This allows your health care providers to make more informed decisions about your care and helps to reduce medical errors and duplicate tests.

By completing and signing this Authorization, I authorize the Hoag entity selected above and affiliates to disclose my health information, for the purposes and to the recipients designated in this Authorization.

Patient Information:

Name: _____ Date of Birth: _____

Purpose of Disclosure and Recipient(s): By signing this Authorization, I authorize past, present or future members of my care team through Care Everywhere to disclose my health information for purposes of enabling members of my care team to provide medical care and treatment to me. The term "treatment" includes activities related to the provision or coordination of health care and related services by one or more members of my care team, including referral or consultation for any condition for which I may receive care.

Information to be Disclosed: All information that the Hoag entity selected above and affiliates maintains about me from any and all dates of treatment or service, including without limitation, encounter information, visit notes, discharge summaries, care plans, laboratory, operative, or pathology results, allergies, medications, problem lists, immunizations, and procedures. This will include information relating that may be particularly sensitive to me, including mental health information, HIV/AIDS test results and information, genetic information, and STD treatment information.

I understand and agree that:

- This Authorization is voluntary. If I do not sign this Authorization, it will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits at the Hoag entity selected above and affiliates. However, I understand that my refusal to sign this Authorization will not affect the Hoag entity selected above and affiliates ability to disclose my information through Care Everywhere where my Authorization is not required by applicable law.
- I may revoke or cancel this Authorization at any time by submitting a written request to the Hoag entity location where I originally signed, except to the extent that others have already acted in reliance upon this Authorization. I understand that even if I revoke my Authorization, the health care providers that accessed my information may have included my health information in their records and are not required to remove my health information from their records.
- Information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.
- This Authorization will expire when the Hoag entity selected above and affiliates is no longer participating in Care Everywhere or upon my written revocation, whichever occurs first.
- I have a right to receive a copy of this Authorization.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

Staff Signature: _____ Date: _____ Time: _____

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# CONDITIONS OF TREATMENT

Name:_____
LAST FIRST MIDDLE

Date of Birth:_____

## Consent to Treatment

I hereby consent to all health care treatment and procedures provided by Hoag Medical Group, 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 Medical Group of any insurance benefits otherwise payable to me or on my behalf for the services rendered. It is agreed that payment to Hoag Medical Group, pursuant to this authorization, by an insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. 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 Medical Group is accurate, and that I am an eligible member. 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 understand that I will be charged a 1% per month finance charge on all accounts over 90 days. 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 Medical Group cannot render medical services on the assumption that the charges will be paid by my insurance company. If Hoag Medical Group has problems collecting payment from me, Hoag Medical Group will also add attorney's fees, collection agency costs and any related fees to my bill.

## Patient Portal

Hoag Medical Group 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 provided to the Patient Portal, so that I may access them electronically as part of my clinical health record. I understand that, unless certain conditions are satisfied, the laboratory test results made available through the Patient Portal will not include test results for HIV, hepatitis, drug abuse, or routinely processed tissues.

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

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____