# 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: ____________

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: ____________

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: ______________________

[1219]

PATIENT LABEL

# AUTHORIZATION TO SHARE PATIENT INFORMATION

Name: ______________________________________________
LAST FIRST MIDDLE

Date of Birth: ______________________

**Phone Messages**

Is there a phone number where the Hoag affiliates and affiliated providers 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 affiliates and affiliated providers 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 affiliates and affiliated providers. 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.

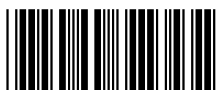
The most current Authorization to Share Patient Information is the active authorization and remains in effect until a new Authorization to Share Patient Information is completed.

Patient/Legal Representative Signature: ______________________ Date: __________ Time: ______AM/PM

If signed by other than patient, indicate relationship: ______________________

Print Name – Legal Representative: ______________________







PATIENT LABEL

☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic ☐ Hoag at Home

# 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: ____________________________________________________________

Patient/Legal Representative Signature:_________________________Date: ______________

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

Print Name (Legal Representative): _______________________________________________

## 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 Print Name: ____________________ Signature:________________Date: _______________

# 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:

____________________

____________________

____________________

____________________

____________________

____________________

| | 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 | | |
| | | |
| | | |



PATIENT LABEL

## 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 LABEL

# HEALTH INFORMATION EXCHANGE AUTHORIZATION

Hoag Memorial Hospital Presbyterian and its affiliates and affiliated providers ("Hoag") 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 Hoag 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 Hoag 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 that may be particularly sensitive to me, including mental health information, HIV/AIDS test results and information, genetic information, and sexually transmitted infection (STI) 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 Hoag. However, I understand that my refusal to sign this Authorization will not affect Hoag's 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 Hoag, 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 Hoag 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.

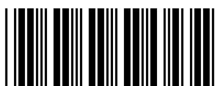
Patient/Legal Representative Signature: ___________________________ Date: __________ Time: __________

If signed by other than patient, indicate relationship: ______________________________________________

Print Name (Legal Representative): __________________________________________________________

Staff Signature: ___________________________________________ Date: __________ Time: __________







PATIENT LABEL

# 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 the Hoag affiliates and affiliated providers, 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 the Hoag affiliates and affiliated providers of any insurance benefits otherwise payable to me or on my behalf for the services rendered. It is agreed that payment to the Hoag affiliates and affiliated providers, 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 the Hoag affiliates and affiliated providers 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. The Hoag affiliates and affiliated providers cannot render medical services on the assumption that the charges will be paid by my insurance company. If the Hoag affiliates and affiliated providers has problems collecting payment from me, it will also add attorney's fees, collection agency costs and any related fees to my bill.

**Patient Portal**
The Hoag affiliates and affiliated providers 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 the laboratory test results made available through the Patient Portal may not include 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.

**By signing below, I acknowledge that I have carefully read, understand, and agree to the terms of the** Hoag affiliates and affiliated providers' **Conditions of Treatment.**

Patient/Legal Representative Signature: ____________________ Date: __________ Time: __________

If signed by other than patient, indicate relationship: ______________________________

Print Name (Legal Representative): ______________________________

PATIENT LABEL