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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: _____

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, or download and complete an authorization form at 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: _____

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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 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: _____

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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:

_____

_____

_____

_____

_____

_____

PATIENT LABEL

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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		

PATIENT LABEL

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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/Legal Representative Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

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 Hoag affiliates and affiliated providers ("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 understand that I will be charged a 1% per month finance charge on all accounts over 90 days, or the maximum allowed by law, whichever is greater. 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.

Telephone and E-mail Communication

I hereby consent to receiving messages as indicated above from 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.

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): _____

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.