PATIENT REGISTRATION / INFORMATION SHEET

Pediatrics

PATIENT INFORMATION

Patient Name: _____
LAST FIRST MIDDLE NICKNAME

Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Social Security Number: _____ Home Phone: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Sibling Name: _____ Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Sibling Name: _____ Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Sibling Name: _____ Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Sibling Name: _____ Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

PARENT/GUARDIAN INFORMATION ☐ Preferred Emergency Contact

Name: _____
LAST FIRST MIDDLE

Social Security Number: _____ Relationship to Patient: _____

Date of Birth: _____ Email Address*: _____

Street Address: _____ City: _____ State: ___ Zip: _____
IF DIFFERENT THAN PATIENT

Home Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Office Phone Number: _____

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

PARENT/GUARDIAN INFORMATION ☐ Preferred Emergency Contact

Name: _____
LAST FIRST MIDDLE

Social Security Number: _____ Relationship to Patient: _____

Date of Birth: _____ Email Address*: _____

Street Address: _____ City: _____ State: ___ Zip: _____
IF DIFFERENT THAN PATIENT

Home Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Office Phone Number: _____

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

PATIENT LABEL

hoag.

Patient Name: _____ Date of Birth: _____

ADDITIONAL EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)
Name: _____ Cell Phone: _____
Relationship to Patient: _____

INSURANCE INFORMATION
To whom should the billing statement be mailed? _____

Primary Insurance: ☐ HMO ☐ POS/PPO ☐ MediCal ☐ Cash ☐ Other: _____
Insurance Company Name: _____ Group #: _____ Policy/ID#: _____
Primary Insurance Subscriber: _____ Relationship to Patient: _____
Date of Birth: _____ Social Security Number: _____

Secondary Insurance: ☐ HMO ☐ POS/PPO ☐ MediCal ☐ Cash ☐ Other: _____
Insurance Company Name: _____ Group #: _____ Policy/ID#: _____
Primary Insurance Subscriber: _____ Relationship to Patient: _____
Date of Birth: _____ Social Security Number: _____

ADDITIONAL PATIENT INFORMATION (OPTIONAL)

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

Spoken Language: _____ Written Language: _____

Who referred you to us? _____

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

Parent/Guardian Signature: _____ Date/Time: _____

PATIENT LABEL

PATIENT HEALTH HISTORY

Pediatrics

Patient Name: _____ Date: _____

Date of Birth: _____

Preferred Pharmacy: _____

Phone Number: _____ Address: _____

Allergies: Any known drug ☐ No ☐ Yes If yes, list: _____

Adverse reactions to vaccines? ☐ No ☐ Yes If yes, list vaccine and reaction: _____

Any environmental or food allergies? ☐ No ☐ Yes If yes, list: _____

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

If yes, please list any medications that are taken on a regular basis (include non-prescriptions).

Medication	Dosage	Frequency

Medication	Dosage	Frequency

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

PREGNANCY AND NEWBORN HISTORY

Any problems during pregnancy? ☐ No ☐ Yes If yes, specify: _____

Birth Hospital: _____ Birth Weight: _____

Delivery: ☐ Vaginal ☐ C-Section Delivery complications: _____

Term: ☐ Premature (___ weeks premature) ☐ Full Term

NICU: ☐ No ☐ Yes If yes, list medical problems: _____

Feeding: ☐ Breast Fed ☐ Formula Fed

Country of Birth: _____

Patient Name: _____ Date: _____

Date of Birth: _____

PATIENT MEDICAL HISTORY

List current medical problems: _____

List previous medical problems with dates: _____

List previous surgeries: _____

List any current pediatric specialists: _____

ER Visits and Hospitalizations: _____

Developmental Delays/Issues? ☐ No ☐ Yes _____

FAMILY HISTORY

(Include parents, siblings, grandparents, aunts and uncles only.)

☐ Alcoholism/Drug Abuse
☐ Asthma/Breathing Problems
☐ Bleeding/Clotting Disorders
☐ Cancer (Type: _____)
☐ Celiac Disease
☐ Crohns/Ulcerative Colitis
☐ Developmental Disorders
☐ Diabetes
☐ Genetic/Metabolic Disorders
☐ Hearing Impairment
☐ Heart Problems/Murmurs
☐ High Cholesterol
☐ High Blood Pressure
☐ Kidney Problems
☐ Mental Health Problems
☐ Migraines
☐ Neurological Disorders
☐ Seizures
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis

List any deaths of immediate family members: _____

SOCIAL HISTORY

List all people who live at home with patient:

Name: _____ Age: _____ Relationship to Patient: _____
Name: _____ Age: _____ Relationship to Patient: _____
Name: _____ Age: _____ Relationship to Patient: _____
Name: _____ Age: _____ Relationship to Patient: _____

ADDITIONAL INFORMATION

Is patient adopted? ☐ No ☐ Yes If yes, can this be discussed in front of patient? ☐ No ☐ Yes

Foster Care? ☐ No ☐ Yes

Recognizing that medical history will affect diagnosis and treatment, I confirm that this Patient Health History is a full and complete statement of my child's pertinent medical history.

Parent/Guardian Signature: _____ Date/Time: _____

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 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: _____

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

hoag.

AUTHORIZATION TO SHARE PATIENT INFORMATION - PEDIATRICS

Patient Name:_____
LAST FIRST MIDDLE

Date of Birth: _____

Phone Messages

Is there a phone number where the Hoag affiliates and affiliated providers can leave detailed messages regarding your child's 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 regarding your child?

☐ Yes ☐ No

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

E-Mail

Do you wish to receive appointment/health screening reminders and other health care messages via e-mail regarding your child?

☐ 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 child's patient information?

☐ Yes ☐ No

If yes, please provide:

Name:_____ Relationship to Patient: _____

Phone Number: _____

I hereby consent to receiving messages regarding my child, 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 my child 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: _____

If signed by other than patient, indicate relationship: _____

Print Name – Legal Representative: _____

PATIENT LABEL

CONSENT TO TREAT A MINOR

I, _____ authorize Hoag affiliates and affiliated providers

to provide medical care for _____ born on _____
Patient Name Date of Birth

including immunizations, physical examinations, and testing/treatment for the purpose of medical diagnosis and treatment, which is deemed advisable by and is to be rendered by the providers and staff of Hoag affiliates and affiliated providers.

This authorization is effective as of _____.
Date

Parent/Legal Representative (Print Name): _____

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

Witness: _____ Date/Time: _____

Note: Minors 12 years and older may consent to medical diagnosis, or treatment of the following: infectious or communicable diseases which must be reported to the local health officer; sexually transmitted infection (STI), rape or HIV testing, mental health therapy or drug or alcohol related problems. Minors of any age may consent to medical diagnosis and/or treatment of the following: contraception, pregnancy, and diagnosis or treatment of sexual assault.

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO THE TREATMENT OF A MINOR

On certain occasions families may wish their child to be brought to our office by someone other than the parent/legal guardian. In these circumstances, written consent is required. If you think that there's a possibility another adult (18 years or older) may bring your child to our office, then please complete and sign this form.

_____ _____
PATIENT LAST NAME (PLEASE PRINT) PATIENT FIRST NAME (PLEASE PRINT)

_____
DATE OF BIRTH

I, the undersigned, parent/legal guardian/person having legal custody of patient named above do hereby authorize:

Grandparent (Name): _____ Phone: _____

Care Giver (Name): _____ Phone: _____

Stepparent (Name): _____ Phone: _____

Other (Name): _____ Relationship: _____ Phone: _____

Other (Name): _____ Relationship: _____ Phone: _____

Other (Name): _____ Relationship: _____ Phone: _____

☐ I decline to add any third parties to consent to any treatment of the minor named above.

The individuals listed above may act as agent(s) to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by and is to be rendered under the general or special supervision of licensed provider employed by Hoag affiliates and affiliated providers, when such diagnosis or treatment is rendered at the office of said provider.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-named agent(s) to give specific consent to any and all such diagnosis or treatment which the provider, in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of California Family Code 6910.

The most current Authorization for Third Party to Consent to the Treatment of a Minor is the active authorization and remains in effect until a new Authorization for Third Party to Consent to the Treatment of a Minor is completed.

Print Name: _____ Signature: _____ Date/Time: _____

Relationship to minor:

☐ Parent

☐ Legal Guardian

☐ Other person having legal custody. Describe legal relationship to minor: _____

PATIENT LABEL