



PATIENT REGISTRATION / INFORMATION SHEET
Hoag Medical Group Pediatrics

PATIENT INFORMATION

Patient Name: LAST FIRST MIDDLE NICKNAME
Date of Birth: Gender: Male Female
Social Security Number: Home Phone:
Street Address: City: State: Zip:
Sibling Name: Date of Birth: Gender: Male Female
Sibling Name: Date of Birth: Gender: Male Female
Sibling Name: Date of Birth: Gender: Male Female
Sibling Name: Date of Birth: Gender: 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: IF DIFFERENT THAN PATIENT City: State: Zip:
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.

PARENT/GUARDIAN INFORMATION

Preferred Emergency Contact

Name: LAST FIRST MIDDLE
Social Security Number: Relationship to Patient:
Date of Birth: Email Address\*:
Street Address: IF DIFFERENT THAN PATIENT City: State: Zip:
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.

QUESTIONNAIRE





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  Asian  African American  Native Hawaiian  
 White  Other  Unknown

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

Language:  English  Other: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

**QUESTIONNAIRE**



# PATIENT HEALTH HISTORY

Hoag Medical Group 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

### QUESTIONNAIRE

Form# 8018

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Rev 06/25/20



[2050]

PATIENT LABEL



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.)

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

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  
 County of Birth: \_\_\_\_\_    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: \_\_\_\_\_

**QUESTIONNAIRE**

PATIENT LABEL



Hoag Medical Group    Hoag Urgent Care    Hoag Physician Partners    Hoag Concierge Medicine    Hoag Specialty Clinic

## 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: \_\_\_\_\_



Hoag Medical Group    Hoag Urgent Care    Hoag Physician Partners    Hoag Concierge Medicine    Hoag Specialty Clinic

## 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: \_\_\_\_\_

**HIE AUTHORIZATION FORM**

Form# 8034

Rev 08/21/20



[0002]

PATIENT LABEL



# HOAG MEDICAL GROUP 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): \_\_\_\_\_

<p>Form# 8035      <b>CONSENT FORM</b>      Rev 08/27/20</p>  <p>[7711]</p>	<p>PATIENT LABEL</p>
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## AUTHORIZATION TO SHARE PATIENT INFORMATION - PEDIATRICS

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

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

**Phone Messages**

Is there a phone number where the Hoag entity selected above and affiliates 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 entity selected above and affiliates 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 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 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 Authorization to Share Patient Information remains in effect until a request to withdraw from this form is submitted in writing by the patient or the patient's legal representative.

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

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

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





Hoag Medical Group  
  Hoag Urgent Care  
  Hoag Physician Partners  
  Hoag Concierge Medicine  
  Hoag Specialty Clinic

### CONSENT TO TREAT A MINOR

I, \_\_\_\_\_ authorize the Hoag entity selected above and affiliates  
 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 the entity selected above and affiliates.

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; STDs, 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.

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**CONSENT TO TREAT A MINOR**

Form# 8009

Rev 08/21/20

PATIENT LABEL



[7079]



Hoag Medical Group    Hoag Urgent Care    Hoag Physician Partners    Hoag Concierge Medicine    Hoag Specialty Clinic

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

\_\_\_\_\_  
PATIENT LAST NAME (PLEASE PRINT)

\_\_\_\_\_  
PATIENT FIRST NAME (PLEASE PRINT)

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
MRN

I, the undersigned, parent/legal guardian/person having legal custody of \_\_\_\_\_ do hereby authorize \_\_\_\_\_ (List additional persons below) 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 the Hoag entity selected above and affiliates, 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.

This authorization shall remain effective until \_\_\_\_/\_\_\_\_/20\_\_\_\_, unless sooner revoked in writing.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE/TIME

Relationship to minor:

- Parent (If parents share medical decision-making authority, both parents must sign this form. If applicable, please see signature line below.)
- Legal Guardian
- Other person having legal custody. Describe legal relationship to minor:  
\_\_\_\_\_

**\*Additional authorized third parties list below:**

\_\_\_\_\_  
\_\_\_\_\_

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

Form# 8036

Rev 08/21/20

PATIENT LABEL



[7080]