



Hoag Medical Group Pediatrics

PATIENT REGISTRATION / INFORMATION SHEET

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ Gender: M F
Social Security Number: _____ Home Phone: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Sibling Name: _____ Date of Birth: _____ Gender: M F
Sibling Name: _____ Date of Birth: _____ Gender: M F
Sibling Name: _____ Date of Birth: _____ Gender: M F
Sibling Name: _____ Date of Birth: _____ Gender: M F

PARENT/GUARDIAN INFORMATION

Preferred Emergency Contact

Name: _____
Social Security Number: _____ Relationship to Patient: _____
Date of Birth: _____ Email Address*: _____
Street Address: _____ 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: _____
Social Security Number: _____ Relationship to Patient: _____
Date of Birth: _____ Email Address*: _____
Street Address: _____ 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.

ADDITIONAL EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)

Name: _____ Cell Phone: _____
Relationship to Patient: _____

Patient Name: _____ Date of Birth: _____

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? _____

*I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that **I am responsible for knowing my benefits / coverage and tests ordered by my physician may NOT be covered.** I will be financially responsible for all charges that are not 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 also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical serviced and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. Hoag Medical Group cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If Hoag Medical Group has problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand the above and agree to hereby give consent for treatment.*

Parent/Guardian Signature: _____ Date: _____



Hoag Medical Group Pediatrics
PATIENT HEALTH HISTORY

Patient Name: _____ Date _____
Date of Birth: _____

Preferred Pharmacy: _____
Phone Number: _____ Address: _____

Allergies: Any known drug allergies? No Yes If yes, list: _____
Adverse reactions to vaccines? No Yes If yes, list vaccine & 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).

Table with 6 columns: MEDICATION, DOSAGE, FREQUENCY, MEDICATION, DOSAGE, FREQUENCY. Includes horizontal lines for data entry.

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

PREGNANCY & 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

PATIENT MEDICAL HISTORY

List current medical problems: _____ List any current pediatric specialists: _____
List previous medical problems with dates: _____ ER Visits & Hospitalizations: _____
List previous surgeries: _____ Developmental Delays/Issues? No Yes

Patient Name: _____ Date _____
Date of Birth: _____

FAMILY HISTORY

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

- | | |
|-----------------------------|------------------------|
| Alcoholism/Drug Abuse | High Cholesterol |
| Asthma/Breathing Problems | High Blood Pressure |
| Bleeding/Clotting Disorders | Kidney Problems |
| Cancer (Type: _____) | Mental Health Problems |
| Celiac Disease | Migraines |
| Crohns/Ulcerative Colitis | Neurological Disorders |
| Developmental Disorders | Seizures |
| Diabetes | Stroke |
| Genetic/Metabolic Disorders | Thyroid Problems |
| Hearing Impairment | Tuberculosis |
| 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? Yes No

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

Country of Birth: _____

Foster Care? Yes No

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: _____



Hoag Medical Group Pediatrics
CONSENT TO TREAT A MINOR

I _____ authorize Hoag Medical Group (“HMG”) including Hoag entities
PARENT/GUARDIAN
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 Hoag Medical Group.

This authorization is effective as of _____.
DATE

PARENT/GUARDIAN NAME (PLEASE PRINT)

DATE

PARENT/GUARDIAN SIGNATURE

WITNESS

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.



Hoag Medical Group Pediatrics

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 _____ 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 Medical Group, 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 judgement may deem advisable.

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

This authorization shall remain effective until _____, unless sooner revoked in writing.
DATE

PRINT NAME

SIGNATURE

DATE

Relationship to minor:

Parent

Legal Guardian

Person having legal custody

WITNESS (PRINT NAME)

SIGNATURE

DATE



Hoag Medical Group Pediatrics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Hoag Medical Group (“HMG”) including Hoag entities, may share my health information for treatment, billing and healthcare operations. I have been provided a copy of HMG’s Notice of Privacy Practices that describes how my health information is used and shared. I understand that HMG has the right to change this notice at any time. I may obtain an additional copy by visiting the website at www.HoagMedicalGroup.com.

I acknowledge receipt of the Notice of Privacy Practices of Hoag Medical Group:

Patient Name: _____

Signature: _____ Date: _____
PATIENT / PARENT / CONSERVATOR / GUARDIAN

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

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 acknowledgment, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgment 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 Name: _____

HMG Staff Signature: _____ Date: _____