hoag
Medical Group
In alliance with St. Joseph Heritage Healthcare

# PATIENT REGISTRATION / INFORMATION SHEET

Name: _____
LAST FIRST MIDDLE
Date of Birth: _____ Gender: ○M ○F Marital Status: _____
Social Security Number: _____ Email Address*: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Primary Language: _____
Race: ○American Indian ○Asian ○African American ○Native Hawaiian ○White ○Other ○Unknown
Ethnicity: ○Hispanic/Latino ○Non-Hispanic/Latino
Religious Preference (optional): _____

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

Employment Status: _____
Employer: _____ Occupation: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Date of Retirement: _____ Spouse's Date of Retirement: _____
IF APPLICABLE 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 result.*
○Yes ○No

Primary Insurance: ○HMO ○POS/PPO ○Medicare ○Cash ○Other: _____
Insurance Company Name: _____ Group Number: _____
Policy / ID Number: _____

Secondary Insurance: ○HMO ○POS/PPO ○Medicare ○Cash ○Other: _____
Insurance Company Name: _____ Group Number: _____
Policy / ID Number: _____

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: _____

*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 and agree to hereby give consent for treatment.*

Patient 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: _____ 2) Name: _____
Specialty: _____ Specialty: _____
Phone: _____ Phone: _____

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? ○No ○Yes
*Please list all allergies including food, medications and environmental and reaction.*

_____

**Do you currently take any medications on a regular basis?** ○No ○Yes
*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 & 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 | |
| ☐ GERD/Heartburn/Reflux | |
| ☐ Gout | |
| ☐ Heart Attack/Heart Disease | |
| ☐ High Blood Pressure | |
| ☐ High Cholesterol | |
| ☐ Kidney Disease | |
| ☐ Lupus | |

Have you had any past medical problems?
○ No ○ Yes If yes, list below:

Have you had any previous surgeries or hospitalizations?
○ No ○ Yes If yes, list details and date below:

**Childhood Diseases**

| | YEAR |
|---|---|
| ☐ Chicken Pox | |
| ☐ Measles | |
| ☐ Mumps | |
| ☐ Polio | |
| ☐ Other: _____ | |

- ☐ 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: _____ _____

**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? ○No ○Yes
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 & CAUSE |
|---|---|---|
| Father | | |
| Mother | | |
| Brother | | |
| | | |
| | | |
| Sister | | |
| | | |
| | | |
| Son | | |
| | | |
| | | |
| Daughter | | |
| | | |
| | | |

## HEALTH MAINTENANCE

When did you last have any of the following:

_____Diabetes Check
_____Prostate Check
_____Colonoscopy
_____Mammogram
_____Pap Smear
_____Cholesterol Check
_____Cardiac Stress Test
_____Bone Density

List year of Last Vaccinations:

_____Tetanus (TD)
_____Influenza (Flu)
_____Pneumonia
_____Shingles (VZV)
_____Hepatitis A
_____Hepatitis B
_____HPV
_____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 seat belt? ○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

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# ACKNOWLEDGMENT 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 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: _____

HMG Staff Signature: _____ Date: _____

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# AUTHORIZATION TO SHARE PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Social Security Number: _____

**Phone Messages**

Is there a phone number where Hoag Medical Group can leave detailed messages regarding your care?

○Yes ○No

If yes, please provide phone number: _____

**Appointment Reminders**

*I would like to receive appointment reminders:*

☐Text Cell Phone Number: _____

☐Phone Phone Number: _____

**Additional Contact**

Is there someone else who Hoag Medical Group can leave messages with and share patient information?

○Yes ○No

If yes, please provide:

Name: _____ Relationship to Patient: _____

Phone: _____

**Expiration**

This authorization expires:

☐Until further notice

☐Insert date: _____

Patient Signature: _____ Date: _____ Time: _____ ○AM ○PM

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

Witness Signature: _____ Date: _____ Time: _____ ○AM ○PM