Hoag Medical Group Pediatrics

PATIENT REGISTRATION / INFORMATION SHEET

PATIENT INFORMATION

Patient Name: ____
LAST FIRST MIDDLE NICKNAME

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: ____
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.*

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.*

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).

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.

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
- 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? 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 TO SHARE PATIENT INFORMATION

Patient 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 child's care?

Yes No

If yes, please provide:

Contact Name: ______________________ Phone number: ______________________

Relationship to Patient: ______________________

Additional Contact

Is there another Parent/Guardian who Hoag Medical Group can leave detailed messages with and share information regarding your child's care?

Yes No

If yes, please provide:

Contact Name: ______________________ Phone number: ______________________

Relationship to Patient: ______________________

Expiration

This authorization expires:

Until further notice

Insert date: ______________________

______________________ ______________________ AM PM

PARENT/GUARDIAN NAME (PLEASE PRINT) DATE TIME

______________________ ______________________

PARENT/GUARDIAN SIGNATURE WITNESS

____

INDICATE RELATIONSHIP TO PATIENT