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Welcome to Hoag Medical Group Pediatrics! Thank you for choosing our practice to care for your children. At Hoag, our patients are our priority, and we want you to know that your family will be well-cared for and respected in all interactions with our team. We are committed to delivering high-quality care, timely visits, and knowledgeable doctors.

In order to help us make your first visit run as efficiently as possible, please remember to bring the following items with you:

☐ Insurance card

☐ Parent's photo ID

☐ Immunization records (yellow card)

☐ Completed new patient registration forms

☐ Records you have from previous doctors' offices

☐ Any forms that you would like us to complete

Prior to your first visit, we encourage you to visit our website to learn more about our practice and each of our doctors:

HoagMedicalGroup.com

We look forward to meeting you!

Sincerely,

The Hoag Medical Group Pediatrics Team

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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

Primary Care Physician (PCP): _____

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: _____

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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: _____

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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.

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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: _____

Appointment Reminders

I would like to receive appointment reminders:

Text Cell Phone Number: _____

Phone Phone Number: _____

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

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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 the Notice of Privacy Practices is subject to change. I may obtain an additional copy by contacting the hospital registration office or by visiting the website at www.HoagMedicalGroup.com.

If you have any questions about HMG's Notice of Privacy Practices, please contact Glenn Chong at 949-791-3100.

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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REQUEST TO RELEASE RECORDS

Patient Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Social Security Number: _____

Use of Disclosure

I hereby authorize:

Name of Organization: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To release copies of patient's records to:

Hoag Medical Group _____
ADDRESS

Mail Fax #: _____ Attn: _____

This authorization applies to the following (please initial next to appropriate section):

_____ All health information pertaining to any medical history, mental or physical condition and treatment received

OR

_____ Only the following records or types of health information:

Date of Service: _____

Service type:

Growth Chart	EKG, EMG, EEG	Radiology Reports	Operative Report
Immunization Record	Outpatient	Emergency	Nurse's Notes
Inpatient	History & Physical	Consults	Lab / Pathology Reports
Discharge Summary	MD Progress Notes	Anesthesia Records	

Other: _____

I specifically authorize release of the following information (check as appropriate):

Alcohol / Drug Treatment Information HIV Test Results Mental health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose for Use / Disclosure:

Patient Request Further Medical Care Insurance Other: _____

Expiration

This authorization expires:

Until further notice

Insert date: _____

Parent/Guardian Signature: _____ Date: _____ Time: _____ AM PM

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

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