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
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

Name: _____________________________________________________________________________________  
LAST FIRST MIDDLE 
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

Name: _____________________________________________________________________________________  
LAST FIRST MIDDLE 
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: _____________________________________________________________________________________  
Relationship to Patient: _________________________________ 
Patient Name: ________________________________________________________________________________  
Date of Birth: _________________________________ 
Cell Phone: __________________________________

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

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<tr>
<th>MEDICATION</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
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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
FAMILY HISTORY
Include parents, siblings, grandparents, aunts & uncles only.
- Alcoholism/Drug Abuse
- Asthma/Breathing Problems
- Bleeding/Clotting Disorders
- Cancer (Type: _________________)
- Celiac Disease
- Crohn's/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: _________________
I _______________________________ authorize Hoag Medical Group (“HMG”) including Hoag entities

and affiliates to provide medical care for __________________________ born on ______________________

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 ____________________.  

_____________________________________________    ____________________________________________

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.
Patient Name: ______________________________________________________________________________

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: ________________________________

____________________________________________   _____________________________________________
PARENT/GUARDIAN NAME (PLEASE PRINT)  DATE  TIME

____________________________________________   _____________________________________________
PARENT/GUARDIAN SIGNATURE  WITNESS

____________________________________________

AM  PM

INDICATE RELATIONSHIP TO PATIENT
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: _________________
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

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: ______________________________ AM

Parent/Guardian Signature: __________________ Date: ______________ Time: ______________ PM

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

Witness Signature: __________________________ Date: ______________ Time: ______________ PM