HOAG URGENT CARE –
PATIENT REGISTRATION / INFORMATION SHEET

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Gender: ☐M ☐F Marital Status: _____
Email Address*: _____ Primary Language: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Primary Care Physician (PCP):_____

Phone Messages

Do you give Hoag Medical Group permission to leave a detailed message regarding your care, at one of the phone numbers provided above? *Please mark at that apply*

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ No, do not leave any messages regarding my care.

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

☐ No ☐ Yes- If yes, please provide:

Contact Name: _____ Relationship: _____
Phone: _____

Emergency Contact

Emergency Contact Name: _____ Relationship: _____
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* **Expiration Date**: _____

Additional Patient Information

Ethnicity: ☐Hispanic/Latino ☐Non – Hispanic/Latino ☐Decline
Race: ☐White ☐Asian ☐Black/African American ☐ American Indian ☐Hawaiian/Pacific Islander ☐Two or more ☐Decline

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 INSURANCE INFORMATION PROVIDED 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 agree to give consent for treatment. I understand that Hoag Medical Group ("HMG") including Hoag entities, may share my health information for treatment, billing and healthcare operations. I understand that I may obtain a copy of the Notice of Privacy Practices that describes how my health information is used and shared, by visiting www.HoagMedicalGroup.com. I understand that HMG has the right to change this notice at any time.
******By providing your email address, you are electing to receive email communication from Hoag Medical Group and its affiliates.*

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Reasons why the acknowledgement was not obtained:

- ☐ Patient of Legal Representative was informed of Notice of Privacy Practices but refused to sign Acknowledgement
- ☐ Patient or Legal Representative unavailable to acknowledge Notice of Privacy Practices
- ☐ Other: _____

Patient Name: _____Date: _____

HMG Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____

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