PATIENT REGISTRATION / INFORMATION SHEET

Hoag Medical Group Pediatrics

PATIENT INFORMATION

Patient Name: _____
LAST FIRST MIDDLE NICKNAME

Date of Birth: _____ Gender: ☐ Male ☐ Female

Social Security Number: _____ Home Phone: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Sibling Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Sibling Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Sibling Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Sibling Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

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.*

PATIENT LABEL

hoag
Medical Group

Patient Name: _____ Date of Birth: _____

ADDITIONAL EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)
Name: _____ Cell Phone: _____
Relationship to Patient: _____

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? _____

Parent/Guardian Signature: _____ Date/Time: _____

PATIENT LABEL