PATIENT REGISTRATION / INFORMATION SHEET

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Gender: ☐ Male ☐ Female Marital Status: _____
Social Security Number: _____ Email Address*: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Primary Language: _____
Race: ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Unknown
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Religious Preference (optional): _____
*By providing your email address, you are electing to receive email communication from Hoag Medical Group and its affiliates.

Employment Status: _____
Employer: _____ Occupation: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Date of Retirement (if applicable): _____ Spouse's Date of Retirement (for Medicare patients): _____

Emergency Contact: _____ Relationship: _____
Street Address: _____ City: _____ State: _____ Zip: _____
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 results. ☐ Yes ☐ No

Primary Insurance: ☐ HMO ☐ POS/PPO ☐ Medicare ☐ Cash ☐ Other: _____
Insurance Company Name: _____ Group #: _____ Policy/ID#: _____

Secondary Insurance: ☐ HMO ☐ POS/PPO ☐ Medicare ☐ Cash ☐ Other: _____
Insurance Company Name: _____ Group #: _____ Policy/ID#: _____

Primary Insurance Subscriber: _____ Relationship: _____
Date of Birth: _____ Social Security Number: _____
Employment Status: _____ Employer: _____
Job Title: _____
Street Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Other Treating Physician: _____

Patient/Legal Representative: _____ Date/Time: _____
If signed by other than patient, indicate relationship: _____
Print Name – Legal Representative: _____