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 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

☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

CONSENT TO TREAT A MINOR

I, ________________________________ authorize the Hoag entity selected above 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 the entity selected above and affiliates.

This authorization is effective as of _________________.
Date

Parent/Legal Representative (Print Name): ____

Parent/Legal Representative Signature: ________________________ Date/Time: __________

Witness: ____ Date/Time: __________

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.

☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

AUTHORIZATION TO SHARE PATIENT INFORMATION - PEDIATRICS

Patient Name: ____
LAST FIRST MIDDLE

Date of Birth: ______________________

Phone Messages

Is there a phone number where the Hoag entity selected above and affiliates can leave **detailed** messages regarding your child's care, appointment/health screening reminders and other health care messages?

☐ Yes ☐ No If yes, please provide phone number: ______________________

Text Messages

Do you wish to receive appointment/health screening reminders and other health care messages via text regarding your child?

☐ Yes ☐ No

If yes, please provide preferred phone number to receive text messages: ______________________

E-Mail

Do you wish to receive appointment/health screening reminders and other health care messages via e-mail regarding your child?

☐ Yes ☐ No

If yes, please provide preferred e-mail address: ______________________

Additional Contact

Is there someone else who the Hoag entity selected above and affiliates can leave **detailed** messages with and share your child's patient information?

☐ Yes ☐ No

If yes, please provide:

Name: ______________________ Relationship to Patient: ______________________

Phone Number: ______________________

I hereby consent to receiving messages regarding my child, as indicated above, from the Hoag entity selected above and affiliates. These parties may use the provided information to contact me by e-mail, live agent, voice mail, text message or pre-recorded message, including by using an auto-dialer or other computer assisted technology, or by any other electronic communication for purposes that include appointment and follow-up health care reminders, pre-registration, surveys, prescription information, health-related products or services that may be of interest, my account(s), assignment of benefits, and financial responsibility. I understand that depending on my phone plan, I could be charged for these calls or text messages. I also understand that providing this contact information and consent are not conditions to my child receiving health care services. With respect to text messages, I understand that I can opt-out at any time by replying "STOP" to the text message from my mobile device.

The Authorization to Share Patient Information remains in effect until a request to withdraw from this form is submitted in writing by the patient or the patient's legal representative.

Patient/Legal Representative Signature: ______________________ Date/Time: ____________

If signed by other than patient, indicate relationship: ______________________

Print Name – Legal Representative: ______________________

PATIENT LABEL

☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that the Hoag entity selected above and affiliates may share my health information for treatment, billing and healthcare operations. I have been provided a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that the Hoag entity selected above and affiliates has the right to change this notice at any time. I may obtain an additional copy by contacting my provider's office selected above.

I acknowledge receipt of the Notice of Privacy Practices:

Patient Name: ____

Signature: ____________________________________ Date: ______________
PATIENT / LEGAL REPRESENTATIVE

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: ____

Staff Signature: ____________________________________ Date: ______________

PATIENT LABEL

☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Specialty Clinic

CONDITIONS OF TREATMENT

Name:____
LAST FIRST MIDDLE

Date of Birth:_______________________________

Consent to Treatment

I hereby consent to all health care treatment and procedures provided by Hoag Medical Group, its physicians, clinicians, and other personnel. Such treatment and procedures may include diagnostic, therapeutic, imaging, and laboratory services.

Financial Responsibility

I hereby assign and authorize direct payment to Hoag Medical Group of any insurance benefits otherwise payable to me or on my behalf for the services rendered. It is agreed that payment to Hoag Medical Group, pursuant to this authorization, by an insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment. I hereby attest that the insurance information provided to Hoag Medical Group is accurate, and that I am an eligible member. I understand that I am responsible for knowing my benefits / coverage and acknowledge that tests ordered by my physician may NOT be 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 hereby authorize the release of all information to other physicians and insurance carriers for the purpose of payment for medical services, and further treatment of care by another physician. I further agree that a photocopy of this form shall be as valid as the original.

Payment is due at the time services are rendered. All charges are my direct responsibility. Hoag Medical Group cannot render medical services on the assumption that the charges will be paid by my insurance company. If Hoag Medical Group has problems collecting payment from me, Hoag Medical Group will also add attorney's fees, collection agency costs and any related fees to my bill.

Patient Portal

Hoag Medical Group utilizes a Patient Portal, which allows me to electronically access my medical information. By signing this form, I hereby request and agree that my medical information and laboratory test results may be provided to the Patient Portal, so that I may access them electronically as part of my clinical health record. I understand that, unless certain conditions are satisfied, the laboratory test results made available through the Patient Portal will not include test results for HIV, hepatitis, drug abuse, or routinely processed tissues.

By signing below, I acknowledge that I have carefully read, understand, and agree to the terms of this Hoag Medical Group Conditions of Treatment.

Patient/Legal Representative Signature: ______________________________ Date: __________ Time: __________

If signed by other than patient, indicate relationship: ____

Print Name (Legal Representative): ____

CONSENT FORM

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PATIENT LABEL