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

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

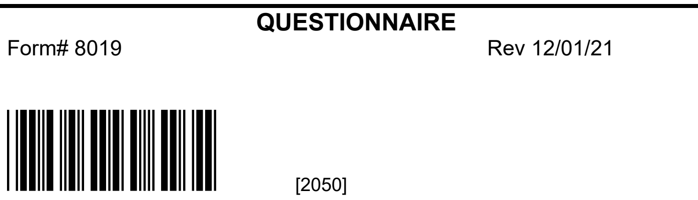
Primary Insurance: ☐ HMO ☐ POS/PPO ☐ Medicare ☐ Cash ☐ Other: __________
Insurance Company Name: __________ Group #: __________ Policy/ID#: __________

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: __________



PATIENT LABEL