☐ 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: _____

**QUESTIONNAIRE**

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

# AUTHORIZATION TO SHARE PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE

Date of Birth: _____

**Phone Messages**

Is there a phone number where the Hoag entity selected above and affiliates can call and leave **detailed** messages regarding your 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?

☐ Yes ☐ No

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

**E-Mail**

Do you wish to receive appointment/health screening reminder and other health care messages via e-mail?

☐ 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 patient information?

☐ Yes ☐ No If yes, please provide:

Name: _____ Relationship to Patient: _____

Phone Number: _____

I hereby consent to receiving messages 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 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 most current Authorization to Share Patient Information is the active authorization and remains in effect until a new Authorization to Share Patient Information is completed.

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

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# 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: _____

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# HEALTH INFORMATION EXCHANGE AUTHORIZATION

The Hoag entity selected above and affiliates participates in a Health Information Exchange called Care Everywhere. Care Everywhere is aimed at improving the coordination and quality of health care services you receive by providing your health care providers with information regarding your current and past health. This allows your health care providers to make more informed decisions about your care and helps to reduce medical errors and duplicate tests.

**By completing and signing this Authorization, I authorize the Hoag entity selected above and affiliates to disclose my health information, for the purposes and to the recipients designated in this Authorization.**

**Patient Information:**

Name: _____ Date of Birth: _____

**Purpose of Disclosure and Recipient(s)**: By signing this Authorization, I authorize past, present or future members of my care team through Care Everywhere to disclose my health information for purposes of enabling members of my care team to provide medical care and treatment to me. The term "treatment" includes activities related to the provision or coordination of health care and related services by one or more members of my care team, including referral or consultation for any condition for which I may receive care.

**Information to be Disclosed**: All information that the Hoag entity selected above and affiliates maintains about me from any and all dates of treatment or service, including without limitation, encounter information, visit notes, discharge summaries, care plans, laboratory, operative, or pathology results, allergies, medications, problem lists, immunizations, and procedures. **This will include information relating that may be particularly sensitive to me, including mental health information, HIV/AIDS test results and information, genetic information, and STD treatment information.**

**I understand and agree that:**

- This Authorization is voluntary. If I do not sign this Authorization, it will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits at the Hoag entity selected above and affiliates. However, I understand that my refusal to sign this Authorization will not affect the Hoag entity selected above and affiliates ability to disclose my information through Care Everywhere where my Authorization is not required by applicable law.
- I may revoke or cancel this Authorization at any time by submitting a written request to the Hoag entity location where I originally signed, except to the extent that others have already acted in reliance upon this Authorization. I understand that even if I revoke my Authorization, the health care providers that accessed my information may have included my health information in their records and are not required to remove my health information from their records.
- Information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy laws.
- This Authorization will expire when the Hoag entity selected above and affiliates is no longer participating in Care Everywhere or upon my written revocation, whichever occurs first.
- I have a right to receive a copy of this Authorization.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

Staff Signature: _____ Date: _____ Time: _____

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# 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 the Hoag entity selected above and affiliates, 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 the Hoag entity selected above and affiliates of any insurance benefits otherwise payable to me or on my behalf for the services rendered. It is agreed that payment to the Hoag entity selected above and affiliates, 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 the Hoag entity selected above and affiliates 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. The Hoag entity selected above and affiliates cannot render medical services on the assumption that the charges will be paid by my insurance company. If the Hoag entity selected above and affiliates has problems collecting payment from me, it will also add attorney's fees, collection agency costs and any related fees to my bill.

## Patient Portal

The Hoag entity selected above and affiliates 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 the Hoag entity selected above and affiliates' Conditions of Treatment.**

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____



PATIENT LABEL

Obstetrics
Gynecology

# Pacific Women's Healthcare Associates

Rhonda M. Flora, M.D., F.A.C.O.G.
Brooke A. Hargrove, M.D., F.A.C.O.G.
Lisa M. Karamardian, M.D., F.A.C.O.G.
Anne M. Kent, M.D., F.A.C.O.G.
Jody W. Lai, M.D., F.A.C.O.G.
Vinita J. Speir, M.D., F.A.C.O.G.
Patricia Strachan, M.D., F.A.C.O.G.
Nicolle S. Underwood, M.D., F.A.C.O.G.
Lisa M.T. Worsch, M.D., F.A.C.O.G.

Patient's name_____ My Doctor's Name_____

## Consent to Use Telemedicine

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine service by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in another state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

*500 Superior Ave., Suite 310, Newport Beach, CA 92663*
*Tel (949) 650-7100 / (949) 644-2722 • Fax (949) 650-3135 / (949) 760-5438*

*4870 Barranca Pkwy., Suite 200, Irvine, CA 92604 • Tel (949) 559-4870 • Fax (949) 559-5628*

***www.pacwha.com***

# Pacific Women's Healthcare Associates

*Obstetrics*

*Gynecology*

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Lisa M.T. Worsch, M.D., F.A.C.O.G.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will I be stored only by my doctor or a service provider selected by my doctor. I understand that dissemination of any personally-identifiable images or information from the telemedicine communication to researches or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine service. I understand the resulting images and audio will become part of my medical record] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with the California law.

12. I understand that the telemedicine service provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

*500 Superior Ave., Suite 310, Newport Beach, CA 92663*
*Tel (949) 650-7100 / (949) 644-2722 • Fax (949) 650-3135 / (949) 760-5438*

*4870 Barranca Pkwy., Suite 200, Irvine, CA 92604 • Tel (949) 559-4870 • Fax (949) 559-5628*

***www.pacwha.com***

hoag.

Pacific Women's Healthcare Associates

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*Newport Beach, CA 92663*
*(949) 650-7100 / (949) 644-2722*

*4870 Barranca Pkwy., Suite 200*
*Irvine, CA 92604*
*(949) 559-4870*

| NAME | SSN | AGE |
|---|---|---|
| ADDRESS | PHONE | |

## I OB-GYN HISTORY

A. NUMBER OF PREGNANCIES _____

NUMBER OF FULL-TERM DELIVERIES _____

NUMBER OF PREMATURE DELIVERIES _____

NUMBER OF ABORTIONS (Miscarriages) _____

NUMBER OF LIVING CHILDREN _____

| DATE | Type of Delivery | M/F | Complications | Days in Hospital |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

B. AGE ONSET OF PERIODS _____

REGULARITY-EVERY _____ DAYS

C. LENGTH IN DAYS OF PERIOD _____

CLOTS: (write yes or no) _____

CRAMPS: (write yes or no) _____

D. DATE OF FIRST DAY OF LAST MENSTRUAL PERIOD _____

WAS IT A NORMAL PERIOD (write yes or no) _____

E. DATE OF LAST PAP SMEAR _____ Normal? Yes ☐ No ☐

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? Yes ☐ No ☐

F. DATE OF LAST MAMMOGRAM _____

NORMAL? Yes ☐ No ☐

## II SURG & MEDICAL HISTORY

### HAVE YOU EVER HAD (if yes, explain)

A. SURGICAL OPERATIONS

B. SERIOUS OR CHRONIC MEDICAL ILLNESSES

C. YES NO

- ☐ ☐ GONORRHEA
- ☐ ☐ SYPHILLUS
- ☐ ☐ INFECTION IN YOUR TUBES
- ☐ ☐ VAGINAL INFECTION
- ☐ ☐ GENITAL HERPES
- ☐ ☐ CHLAMYDIA
- ☐ ☐ GENITAL WARTS

### SEXUAL HISTORY

SEXUALLY ACTIVE Yes ☐ No ☐

PAINFUL INTERCOURSE Yes ☐ No ☐

DISCHARGE/BLEEDING AFTER INTERCOURSE Yes ☐ No ☐

D. CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS WHICH YOU (OR YOUR FAMILY) HAVE HAD

| Patient | Family | | Patient | Family | |
|---|---|---|---|---|---|
| ☐ | ☐ | TUMOR OR MASSES OF THE BREASTS | ☐ | ☐ | VARICOSE VEINS |
| ☐ | ☐ | DIABETES | ☐ | ☐ | PHLEBITIS (Blood Clots in Veins) |
| ☐ | ☐ | EPILEPSY OR CONVULSIONS | ☐ | ☐ | PULMONARY EMBOLUS (Clots in Lungs) |
| ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ | ASTHMA |
| ☐ | ☐ | MIGRAINE HEADACHES | ☐ | ☐ | THYROID DISEASE |
| ☐ | ☐ | BLURRED OR ABNORMAL VISION | ☐ | ☐ | FIBROIDS (Tumors in Uterus) |
| ☐ | ☐ | LEG CRAMPS | ☐ | ☐ | CANCER (Specify) _____ |
| ☐ | ☐ | FLUID RETENTION | ☐ | ☐ | HEART ATTACK |
| ☐ | ☐ | DEPRESSION (required treatment) | ☐ | ☐ | HEART DISEASE |
| ☐ | ☐ | GASTROINTESTINAL DISEASE | ☐ | ☐ | STROKE |
| ☐ | ☐ | KIDNEY DISEASE OR BLADDER INFECTION | ☐ | ☐ | OTHER (Specify) _____ |
| ☐ | ☐ | HEPATITIS (Liver Disease) | | | |

E. DO YOU SMOKE? Yes ☐ No ☐

DO YOU DRINK? Yes ☐ No ☐

SOCIAL DRUGS? Yes ☐ No ☐

Patients Name: _____ Date: _____

## III ALLERGIES - MEDICATIONS

A. CHECK ANY OF THE FOLLOWING TO WHICH YOU ARE ALLERGIC.

- o PENICILLIN
- o TETRACYCLINE
- o SULFA
- o ASPIRIN
- o CODEINE
- o CONTRACEPTIVE CREAM
- o OTHER MEDICATIONS *(Give Names)*
- o _____

B. LIST ALL MEDICATIONS *(Including Birth Control Pills)* WHICH YOU ARE PRESENTLY TAKING:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## IV BIRTH CONTROL METHODS

A. WHAT FORM OF BIRTH CONTROL ARE YOU PRESENTLY USING?

- o PILL
- o IUD
- o DIAPHRAGM
- o CONDOM
- o FOAM OR CREAM
- o WITHDRAWAL
- o RHYTHM
- o VASECTOMY
- o TUBAL LIGATION
- o HYSTERECTOMY
- o NONE

B. DO YOU PLAN TO CONTINUE PRESENT FORM OF BIRTH CONTROL? ☐ Yes ☐ No

C. THE NEW METHOD YOU WISH TO USE IS:_____

Pacific Women's Healthcare Associates

# Cancer Risk Assessment Form

_____ _____/_____/_____ _____/_____/_____

Patient Name Date of Birth Date Completed

*This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.*

**Circle Y for those that apply to <u>YOU and/or YOUR FAMILY</u> (consider all relatives on both mother's and father's side). YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED**. ***Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins, Great Grandparents, Great Aunt/Uncle***

| **TYPES OF CANCER** | | | **RELATIONSHIP TO FAMILY MEMBER with CANCER and AGE at DIAGNOSIS** | | |
|---|---|---|---|---|---|
| | | | **SELF/ SIBLING** | **MOTHER or Relatives on MOTHERS's side** | **FATHER or Relatives on FATHER's side** |
| | | *EXAMPLE:* | Me 35<br>Sister 40 | Aunt 35 | Grandmother 75 |
| Y | N | Breast cancer **<u>before</u>** age 50? | | | |
| Y | N | Multiple breast cancers on the **<u>same side</u>** of the family?<br>• If 2 breast cancers, one must be **<u>at or before</u>** age 50<br>• If 3+ breast cancers, they can be at **<u>any age</u>** | | | |
| Y | N | Ovarian cancer **<u>at any age</u>**? | | | |
| Y | N | Male breast cancer **<u>at any age</u>**? | | | |
| Y | N | Pancreatic cancer **<u>at any age</u>**? | | | |
| Y | N | Metastatic prostate cancer **<u>at any age</u>**? | | | |
| Y | N | Ashkenazi Jewish ancestry ***with*** breast, ovarian, or pancreatic cancer **<u>at any age</u>**? | | | |
| Y | N | Colon Cancer **<u>before</u>** age 50? | | | |
| Y | N | Endometrial Cancer **<u>before</u>** age 50? | | | |
| Y | N | Colon **<u>and/or</u>** Endometrial Cancer at any age **<u>AND</u>** two or more of the following cancers in the same person or on the same side of the family **<u>at any age</u>**? (*ovarian, stomach, renal pelvis, small bowel, pancreas, brain)* | | | |
| Y | N | **<u>Ten or more</u>** lifetime colon polyps? | | | |
| Y | N | Any other cancers? | | | |

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No ☐ Do Not Know

Patient signature: _____ Date: _____

For Office Use Only:

Patient offered testing ☐ Accepted ☐ Declined Reason for decline: _____

☐ Does Not Meet Criteria ☐ Sample Collected

**Physician Signature**_____