

# HUNTINGTON MEDICAL FOUNDATION

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## WELCOME!

Dear Patient:

Welcome to Huntington Medical Foundation. Thank you for choosing us for your health care needs. In order to allow our staff and doctors to focus their energy on your health care needs, please take a few moments to read and complete the following package of information before you arrive in our office.

### Your first appointment

When you come for your first appointment, please bring the following documents:

- ✓ Completed Patient Registration Form
- ✓ Completed Health Questionnaire (as appropriate based on patient's age)
- ✓ Completed Authorization For Release of Information (if applicable or if you have a personal representative (spouse) who you are authorizing us to communicate with regarding your care.)
- ✓ Completed Insurance Eligibility Waiver
- ✓ Your current insurance identification card

Also, please read these documents:

- ✓ Notice Of Privacy Practices  
When you arrive in the office, you will be asked to sign an acknowledgment that simply states you were offered a copy.
- ✓ Office Policies

In addition, you will be asked to read and sign the Physician-Patient Arbitration Agreement when you visit the office for the first time.

**Don't forget!** Please bring your current insurance identification card each time you visit our office.

We are here to assist you in any way we can and look forward to a mutually rewarding relationship.

Sincerely,

All HMF Staff

- 375 Huntington Dr., Suite G, San Marino, CA 91108 • 626/441-4231
- 10 Congress St., Suite 208, Pasadena, CA 91105 • 626/795-4210
- 65 N. Madison Ave., Suite 800, Pasadena, CA 91101 • 626-792-3142
- 800 S. Santa Anita Ave., Suite 201, Arcadia, CA 91006 • 626/447-3516
- 1346 E. Foothill Blvd., Suite 201, La Cañada, CA 91001 • 818/790-5583
- 55 E. California Bl., Ste. 200, Pasadena • 91105 • 626/449-7350 (pediatrics)
- 55 E. California Bl., Ste. 204, Pasadena • 91105 • 626/397-8323 (specialists)

# HUNTINGTON MEDICAL FOUNDATION

## PATIENT REGISTRATION

### Patient Personal Information

Name \_\_\_\_\_  
(Parents may register all their children at once in the next section.)

Address \_\_\_\_\_

City/ST/Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle gender: Female Male

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Occupation/Student \_\_\_\_\_

Employer/School \_\_\_\_\_

Referred by \_\_\_\_\_

### Pediatric Patient Registration (to register all siblings with one form)

Child's name \_\_\_\_\_

Date of birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle gender: Female Male

Child's name \_\_\_\_\_

Date of birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle gender: Female Male

Child's name \_\_\_\_\_

Date of birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle gender: Female Male

Child's name \_\_\_\_\_

Date of birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle gender: Female Male

Child's name \_\_\_\_\_

Date of birth : \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle gender: Female Male

### Responsible Party Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City/ST/Zip \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Relationship to Patient:

- HUSBAND  WIFE  FATHER  MOTHER  
 STEP-FATHER  STEP-MOTHER  LEGAL GUARDIAN

### Insurance Information

Insurance carrier \_\_\_\_\_

Insurance I.D. # \_\_\_\_\_

Type (circle one): HMO PPO POS Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Spouse/Parent Information

(Complete only if spouse or parent is not the responsible party)

Name \_\_\_\_\_

Address \_\_\_\_\_

City/ST/Zip \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Relationship to Patient:

- HUSBAND  WIFE  FATHER  MOTHER  
 STEP-FATHER  STEP-MOTHER  LEGAL GUARDIAN

### Emergency Contact

Name \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Phone (Circle Home | Work | Cell): (\_\_\_\_) \_\_\_\_\_

Relationship to Patient:

- HUSBAND  WIFE  FATHER  MOTHER  
 STEP-FATHER  STEP-MOTHER  LEGAL GUARDIAN  FRIEND

### Authorization

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up lab information, prescriptions, other referral information from a Huntington Medical Foundation office and to make and receive phone calls regarding my health and or the billing related to the services provided to me by Huntington Medical Foundation.

Spouse: (NAME) \_\_\_\_\_

Caregiver: (NAME) \_\_\_\_\_

Children: (NAME(S)) \_\_\_\_\_

Other: (NAME(S)) \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
SIGNATURE OF PATIENT OR REPRESENTATIVE TODAY'S DATE

# HUNTINGTON MEDICAL FOUNDATION

## HEALTH ASSESSMENT QUESTIONNAIRE

Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_

Occupation \_\_\_\_\_

### Past Medical Problems (operations, illnesses, injuries)

Year	Problem	Hospital

### Present or Recurrent Medical Problems

Year	Problem

### Medications (indicate dose and frequency)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

### Allergies to Medications (indicate reaction, i.e. rash, vomiting, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

### Family History

Relationship	Age if Living	Age at Death	State of Health or Cause of Death
Father			
Mother			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Child:			
Child:			
Child:			
Child:			
Child:			

Illness	Family member with Illness	Age at Onset
Breast Cancer		
Colon Cancer		
Prostate Cancer		
High Blood Pressure		
Coronary Artery Disease		
Diabetes		



# HUNTINGTON MEDICAL FOUNDATION

## AUTHORIZATION FOR RELEASE OF INFORMATION

Although your privacy has always been important to us, we are now mandated, due to a recent federal law called HIPAA (Health Insurance Portability and Accountability Act of 1996), to obtain authorization to share your Protected Health Information with others. This means that if you routinely have someone else involved in your care or the care of your children, we will need to have an authorization on file in order to continue to accommodate you. If any of the following scenarios fit your situation, please complete this authorization form and return it to us for our files.

- ✓ Someone other than the parent or legal guardian brings your children for services at any of our offices. Please list all individuals by name who are authorized by you to be present during a doctor visit.
- ✓ Someone other than the patient, parent or legal guardian picks up lab slips, prescriptions or other information from our offices on behalf of the patient. Please list all individuals by name that are authorized to do so, including a spouse.
- ✓ Someone other than the patient, parent or legal guardian calls on the phone requesting information such as immunization records, test results, appointments, prescription refills or regarding billing matters. Please list all individuals by name that we are authorized to speak with about these matters, including a spouse.

Please be sure to list authorized individuals *by name* and not by relationship to the patient, such as "nanny". The patient, parent or legal guardian must sign the authorization. Once authorization is given, it may be revoked at any time in writing

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I authorize HUNTINGTON MEDICAL FOUNDATION to use/disclose my health information as described below. I understand that this authorization is voluntary and that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I understand that a photocopy or facsimile of this authorization is as valid as the original.

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person(s) authorized to receive this information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information that may be used or disclosed:

- Record of visits (specify dates)
- Record of visits (all)
- Discharge summary
- History/Physical
- Consultation Report(s)
- Operative Report(s)
- Problem List
- Progress Notes
- Immunization Records
- Medication Records
- Laboratory Reports
- X-Ray, MRI, CT Reports
- Echo, Stress Tests, Holter Monitor Tests
- EKG Report(s)
- Mental health/Alcohol/Drug Abuse Treatment
- AIDS or HIV Information
- Hepatitis Information
- Entire Medical record
- Billing Record(s)
- Other (specify)

I understand that I may revoke this authorization at any time by notifying Huntington Medical Foundation in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires on \_\_\_\_/\_\_\_\_/\_\_\_\_.

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
SIGNATURE OF PATIENT OR REPRESENTATIVE      TODAY'S DATE

\_\_\_\_\_  
PRINTED NAME OF PATIENT'S REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

