

HUNTINGTON MEDICAL FOUNDATION

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
- 301 Huntington Drive, Suite 320, Arcadia, CA 91007 • 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		

