TORRANCE MEMORIAL
A CEDARS-SINAI AFFILIATE

Torrance Memorial Physician Network

PATIENT REGISTRATION FORM

Patient Information

Patient's Last Name	First	M.I.	Date of Birth	Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown
Primary Language	Preferred Name		Marital Status	
Race: (check all that apply) ☐ White ☐ Black / African American ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian / Pacific Islander ☐ Decline to Answer ☐ Other_____				**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Patient's Street Address Apt #	City		State	Zip Code
Primary/Cell Phone ( )	Home Phone ( )		Day/Work Phone ( )	
E-mail Address	Patient's Social Security Number		Primary Care Physician	
Emergency Contact Full Name	Relationship		Home Phone ( )	Cell Phone ( )
Employment Status: ☐ Full Time ☐ Part Time ☐ Student ☐ Self-Employed Time ☐ Not Employed ☐ Retired Date: _____				
Patient's Employer Name	Employer Phone ( )		Patient's Occupation	
Employer Address	City	State	Zip Code	
Is there any other information you would like your physician to know? (e.g. language translator needed, preferred pronoun, blind or visually impaired, hard of hearing, etc.)				

Insurance Information

Primary Insurance Company	Member ID	Group#	
Subscriber's Full Name		Subscriber's Date of Birth	
Subscriber's Social Security#	Subscriber's Address		
Subscriber's Employer Name	Relationship to Patient	Subscriber's Employment Status ☐ Full Time ☐ Part Time ☐ Retired Date: _____	
Subscriber's Employer Address	City / State / Zip Code		Employer Phone ( )
Secondary Insurance Company	Subscriber's Full Name	Member ID	Group#
Subscriber's Date of Birth	Relationship to Patient	Secondary Subscriber Address	

Guarantor person responsible

Guarantor's Last Name	First	M.I.	Date of Birth	Relationship to Patient
Street Address	City		State	Zip Code
Home Phone ( )	Work Phone ( )		Cell Phone ( )	

Acknowledgement: By signing below, I signify that the information I have provided is accurate to the best of my knowledge. This signature also signifies my general consent for treatment to Torrance Health Association DBA Torrance Memorial Physician Network to provide any and all medical treatment to myself or my dependent.

_____ _____

Signature of Patient or Patient Representative Today's Date

Revised 02/28/2022

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HEALTH QUESTIONNAIRE

Name: _____ Today's Date: _____ Date of Birth: _____

Completed by if other than patient: _____ Relationship: _____

Primary Care Physician: _____

Allergies? ☐ Yes ☐ No

Allergy:	_____	Reaction:	_____
Allergy:	_____	Reaction:	_____
Allergy:	_____	Reaction:	_____
Allergy:	_____	Reaction:	_____

List of Medications: (Please list all medications you take, including over-the-counter medications, vitamins, laxatives, and herbal supplements. Also include new medications prescribed since your last visit or changes in dosage)

Medication/Supplement:	Dose:	Taken How/How Often?	Who Prescribed This?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vaccines:	**Date(s):**		
Covid	_____	_____	_____
HPV	_____	_____	
Hep A	_____	_____	
Hep B	_____	_____	
Influenza	_____		
Meningitis	_____	_____	
Pneumonia	_____	_____	
Tdap/Tetanus	_____		
Shingles	_____	_____	

Revised 02/28/2022

Name: _____ Today's Date: _____ Date of Birth: _____

Past Surgical History: (Please list most recent first)

Surgical Procedures:	Year:	Surgical Procedures:	Year:
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any of the following conditions: Please ✓ if, Yes

Alcoholism		Diabetes		Obesity	
Allergies		Drug Addiction		Osteoarthritis	
Alzheimer's Disease		Eczema/Hives		Osteoporosis	
Asthma		Heart Disease (CAD)		Seizure Disorder	
Bleeding Disorder		High Blood Pressure		Stroke (CVA)	
Blood Clots		High Cholesterol		Thyroid Disease	
Cancer		Mental Illness		Other:	
Depression		Migraines			

Social History:

Tobacco Use: ☐ Never ☐ Former ☐ Current
# of Cig/Packs per Day: _____ # of Years Smoked: _____
Type: _____
Age Started: _____ If former, quit at age: _____

Alcohol Use: ☐ Never ☐ Former ☐ Current
Type: _____
Drinks/Week: _____

Illicit Drugs: ☐ Never ☐ Former ☐ Current
Type: _____

Employment: Are you currently employed? ☐ Yes ☐ No ☐ Retired

Occupation: _____ Hours worked per week: _____

Is your work satisfying and free from undue pressure or stresses? ☐ Yes ☐ No Do you miss much time from work? ☐ Yes ☐ No

Exercise: Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercise? _____Hours per day___

Marital Status: Single Married Separated Divorced Widowed # of Previous Marriages ___

Gender Identity: ☐ Female ☐ Male

☐ Transgender Female/Transwoman/MTF ☐ Transgender Male/Transman/FTM

☐ Nonconforming neither exclusively female nor male Other specify _____

Children: Number of children: ___ How is your relationship with your children? _____

Nutrition: Are you on a specific diet? ☐ Yes ☐ No If yes, what type of diet? _____

Caffeine Intake: ☐ Yes ☐ No If yes, what type of Caffeine? _____ Daily Intake:_____

Revised 02/28/2022

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Torrance Memorial Physician Network. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Please note, our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice upon request at any Torrance Memorial Physician Network office/facility or at our website www.tmphysiciannetwork.org. If you have any questions about our Notice of Privacy Practices, please contact the Torrance Memorial Physician Network Privacy Officer at (310) 784-4994.

I acknowledge receipt of the Notice of Privacy Practices of Torrance Memorial Physician Network.

Patient's Name (Please print)	Date of Birth
Signature of Patient or Patient Representative	Today's Date
Relationship to Patient	

FINANCIAL AGREEMENT

We would like to thank you for choosing Torrance Memorial Physician Network for your healthcare. Please ask for clarification if needed, and sign in the space provided. A copy of this agreement will be given to you.

All patients must complete the Patient Information and Insurance Form before seeing the physician/provider.

Regarding Insurance Billing

You are responsible to provide accurate insurance information for covered healthcare services. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for payment in full. We will bill your insurance company as a courtesy. It is your responsibility to know your benefits and how they will apply to your treatment by the physician/provider. We do not have access to the details of your insurance policy.

Your co-insurance and/or unmet deductible is your financial responsibility. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or co-insurance, and service amounts. All co-pays will be collected at the time of service. If you are scheduled to have a surgical procedure you may be required to pay a deposit. Any deposits will be applied toward any out-of-pocket expenses deemed patient responsibility by your insurance company. You may forfeit part of this deposit if you do not cancel your surgery in a timely fashion. Please ask the physician's care team for further details regarding this deposit.

Form Fees

There is a fee (per form) for completing disability, insurance, and/or medical imaging copies. Payment is due when the form is completed. Please allow 5 business days to complete the form(s). For a full list of fees, please see receptionist.

I understand that by signing this form, I am accepting financial responsibility for all services that I receive.

Patient's Name (Please print)	Date of Birth
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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of your medical information. Failure to provide all information requested may invalidate this Authorization.

This Authorization is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Use and Disclosure of Health Information. I hereby authorize Torrance Memorial to release my Protected Health Information (PHI), by means of verbal communication in person, via telephone, mail, or facsimile to the following individuals:

Name: **Relationship:**

_____ _____

PLEASE USE ONE AUTHORIZATION PER INDIVIUAL DESIGNEE

This Authorization shall remain in effect unless and until which time I it is revoked. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

Torrance Memorial Physician Network
ATTN: Privacy Officer
23326 Hawthorne Boulevard, Suite 200
Torrance, CA 90505

Revocation. You have the right to revoke this Authorization, in writing, at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) have already made, in reliance on this Authorization, before the time you revoke it.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Today's Date

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COMMUNICATION AND INFORMATION SHARING

Patient Name: _____ **Date of Birth:** _____

The Patient Portal is our primary method for confidential communication. This authorization allows you to have access to online appointment requests, to send messages to the office and online access to your medical information.

☐ Yes – Please communicate with me by secure email through the Patient Portal.

My email address is _____. I will let you know right away if my email address changes.

☐ No – Please do not communicate with me via E-mail.

Texting. This authorization allows us to communicate through our Automated Appointment Reminder, Messaging and Survey System. By providing your cell phone number we will automatically enroll you in these systems.

☐ Yes – Please communicate with me by text message for reminders and surveys.

My cell phone number is _____. I will let you know right away if my cell phone number changes.

☐ No – Please do not communicate with me by text message.

Verbal Communication. This authorization allows Torrance Memorial to leave voicemail messages at a designated phone number. To protect your confidentiality, we will not leave messages with your spouse, family members or any other individual unless you specifically give your permission in writing to do so, using the "Authorization for Use or Disclosure of Medical Information" form.

☐ Yes – Please communicate with me by private phone number.

My phone number is _____. I will let you know right away if my phone number changes.

☐ No – Please do not communicate with me by private phone number.

Consent to Photography I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images for the purposes of my diagnosis or treatment or for Torrance Memorial operations, including security, peer review, education or training programs.

Disease Registries and California Immunization (CAIR) Registries are computer-based tracking systems developed to assist medical providers and other approved agencies to track and review medical information for individuals to assess needs and avoid redundant immunizations and control disease outbreaks. Torrance Memorial shares information with CAIR Registries.

No Obligation to Sign. You are not under any obligation to sign this form, and you may refuse to do so. Torrance Memorial may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) have already made, in reliance on this authorization, before the time you revoke it.

Patient Name	Date of Birth
Patient Signature	Today's Date