

Long Beach Medical Center Executive Health Program

Dear New Patient,

Attached is your New Patient Registration Package. Please fill out all pages completely and return them at least **seven days before** your scheduled appointment. Incomplete forms or missing information may lead to delays in registration.

Please e-mail your completed New Patient Registration Package to:

LMCExecutiveHealth@memorialcare.org

If you have questions or need additional information, please call the office at **(562) 933-4700**.

Thank you,

MemorialCare Long Beach Medical Center Executive Health Program

Executive Health Program

Patient Registration

First Name Last Name MI Date of Birth

Address City State Zip

Please Check Primary Phone Home Phone Work Phone Cell Phone

Other Name(s) Used E-mail Address

Gender M F Nonbinary SSN N/A Preferred Language Driver's License N/A

Marital Status Married Single Divorced Separated Widowed Life Partner
Preferred Contact Mail Home Phone Day Phone Cell Phone Patient Portal, (MyChart)
Ethnicity Cambodian Filipino Hispanic/Latino Non-Hispanic
Race American Indian or Alaskan Native Asian Black or African American Native Hawaiian/Other Pacific Islander White Other

Primary Care Provider Referring Provider

Responsible Party (Guarantor) Same as patient

First Name **COLB** Last Name **COLB** MI **N/A** Date of Birth **N/A**

Address **COLB** City **COLB** State Zip

Please Check Primary Phone Home Phone Work Phone Cell Phone

Other Name(s) Used E-mail Address

SSN **N/A** Relationship to Patient **employer** Preferred Language Driver's License **N/A**

I/We do hereby consent to and authorize the performance of all examinations, treatments, surgeries and medical services, including telehealth services deemed advisable by the physicians and staff of the MemorialCare Medical Foundation affiliated medical groups to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I consent to be photographed or videotaped while receiving treatment for purposes of my diagnosis or treatment. I understand that photography for other purposes (e.g. marketing or public relations) requires separate consent. I understand that my provider may participate in teaching programs and that, unless I notify my provider to the contrary in writing, I consent to receive treatment from residents, fellows, or students, all of whom are under appropriate supervision as required by their medical education and clinical training programs. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature of Patient/Responsible Party Date

Name of Patient/Responsible Party (Please Print) Relationship to Patient

Executive Health Program

Patient Registration continued

Pharmacy Information

Preferred Pharmacy

Name	Name
Address	Address
Phone	Phone
Fax	Fax

Secondary Pharmacy

Advanced Directives

None
 Do Not Resuscitate
 Durable Power of Attorney
 Living Will
 HC Proxy
 Date Reviewed: _____

Allergies - List all known allergies (medications, food, animals, environmental, etc.)

No known allergies

Medications - List all medications you currently take (prescription and non-prescription)

I do not take any medications

Medication Name	Dosage & Frequency

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year	Condition	Year
<input type="checkbox"/> None		<input type="checkbox"/> Cerebrovascular Accident		<input type="checkbox"/> Irritable Bowel Disease	
<input type="checkbox"/> Allergies		<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Anemia		<input type="checkbox"/> COPD (Emphysema)		<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Angina		<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Depression		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Gallbladder Disease		<input type="checkbox"/> Peptic Ulcer Disease	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> GERD (Reflux)		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Hepatitis C		<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Hyperlipidemia		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Cancer – Type		<input type="checkbox"/> Hypertension		<input type="checkbox"/> Other	
				<input type="checkbox"/> Other	

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Patient Registration continued

Surgical History – Check if you have received the following procedures, and year performed.

Surgical Procedure	Year	Surgical Procedure	Year	Surgical Procedure	Year
<input type="checkbox"/> None		<input type="checkbox"/> Hip Replacement		Female Only	
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Knee Replacement		<input type="checkbox"/> Augmentation Mammoplasty	
<input type="checkbox"/> Angioplasty w/Stent		<input type="checkbox"/> LASIK		<input type="checkbox"/> Bilateral Tubal Ligation	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Liver Biopsy		<input type="checkbox"/> Breast Biopsy	
<input type="checkbox"/> Arthroscopy Knee		<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Cesarean Section	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Small Bowel Resection		<input type="checkbox"/> D and C	
<input type="checkbox"/> CABG (heart bypass)		<input type="checkbox"/> Thyroidectomy		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Carpal Tunnel Release		<input type="checkbox"/> Tonsillectomy		<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> Cataract Extraction		Male Only		<input type="checkbox"/> Myomectomy	
<input type="checkbox"/> Cholecystectomy		<input type="checkbox"/> Prostate Biopsy		<input type="checkbox"/> Reduction Mammoplasty	
<input type="checkbox"/> Colectomy		<input type="checkbox"/> TURP (Transurethral Resection of the Prostate)		<input type="checkbox"/> TAH/BSO	
<input type="checkbox"/> Colostomy		<input type="checkbox"/> Vasectomy		<input type="checkbox"/> Vaginal Hysterectomy	
<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Other		<input type="checkbox"/> Other	
<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Other		<input type="checkbox"/> Other	

Family History – Check if any family member(s) has had any of the following conditions.

Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CAD (Heart Attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cancer – Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CVA (Stroke)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hearing Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hyperlipidemia (High Cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Irritable Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> PVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Patient Registration continued

Social History for Adult Patient

Occupation _____

Employer _____

Do you have any children? Yes No How Many?: Female(s): Male(s):

Tobacco Use No
 Daily Weekly Less Former / Year Quit _____

Chewing Pipe Cigar Cigarette
 Smokeless Brand: _____

Alcohol Use No
 Daily Weekly Less Former / Year Quit _____

Beer Wine Liquor
 Other: _____

Exercise None
 Activity Moderate Vigorous Sedentary Days/Week: _____

Sleep Pattern
 Changes No Changes

Caffeine Use No
 Daily Weekly Less Former / Year Quit _____

Chocolate Soda Coffee Tea Tablets
 Other: _____

Tobacco Exposure: Yes No
 Smokers at home? Yes No

Patient is a current smoker: Yes No

Health Maintenance – Check if you have received the following, and date of most recent exam.

Exam	Date	Exam	Date	Exam	Date
<input type="checkbox"/> None		<input type="checkbox"/> Eye Exam		<input type="checkbox"/> Mammogram	
<input type="checkbox"/> Breast Exam		<input type="checkbox"/> FOBT (stool card for hidden blood)		<input type="checkbox"/> PAP Test	
<input type="checkbox"/> Cardiac Stress Test		<input type="checkbox"/> Foot Exam		<input type="checkbox"/> Physical Exam	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> GYN Exam		<input type="checkbox"/> Pneumococcal Vaccine	
<input type="checkbox"/> DEXA Scan		<input type="checkbox"/> Influenza Vaccine		<input type="checkbox"/> Pulmonary Function Test	
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> Lipid Panel		<input type="checkbox"/> Sigmoidoscopy	
<input type="checkbox"/> EKG				<input type="checkbox"/> Tetanus Vaccine	

Immunization History (bring records with you)

Vaccine	Date	Date	Date	Date
COVID				
Hepatitis A				
Hepatitis B				
Haemophilus Influenza type B (Hib)				
Influenza				
Tetanus, Diphtheria, Pertussis (Tdap)				
Tetanus, Diphtheria (Td) Booster				
Pneumococcal: PREVNAR 20 (PCV13 - PCV20)				
Pneumococcal: Pneumovax 23 (PPSV23)				
SHINGRIX (herpes zoster/shingles)				
Measles, Mumps, Rubella (MMR)				
Other:				
Other:				
Other:				
Other:				