Harbor Medical Associates, Inc.
3 Corporate Plaza Drive Suite 140
Newport Beach, CA. 92660
Ph: (949) 642-7757 Fax: (949) 642-5091

PATIENT INFORMATION

Date___________________________

Name (First)______________________________(Middle) _______________________(Last)__________________________

Date of Birth___________________________Gender (M / F)______________Marital Status__________________________

Social Security # __________________________________Height ______________________Weight_________________lbs.

Smoking Status ☐ Current smoker ☐ Former smoker ☐ Never a smoker

Home Address ____Apt.#_________

City____State____________Zip______________________

Cell Phone # _______________________Home Phone #________________________E mail___________________________

Communication Preference ☐ Cell Phone ☐ Home Phone ☐ E Mail ☐ Patient Ally

List the persons you would like to authorize to call on your behalf

Do you authorize a relative or acquaintance to call on your behalf? ☐ NO ☐ YES

Check all that apply:

☐ Make/Cancel/ Confirm appointments on my behalf ☐ Give the Doctor a message on my behalf

☐ Request medication adjustments on my behalf ☐ Pick up Prescription/physician's letter on my behalf

Name of person authorized ____ Relationship ______________________

Name of person authorized ____ Relationship ______________________

Employer Name ____Occupation _______________________________

Employer Address____

City____State__________Zip_______________________

Referred By ____ Phone #__________________________

Primary Care Physician (PCP)____ Phone # _________________________

Reason for your visit ?____

Emergency Contact _________________________________Relationship _________________Phone #__________________

To transmit Electronic Prescriptions we need your pharmacy information

Pharmacy Name___________________________Address____

City__________________________State_________Zip ________________ Phone # _________________________________