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_____ Age_____Sex_____Marital Status_____

Social Security # _____ Height _____feet_____inches Weight _____ lbs.

Race ☐ Asian ☐ African Descent ☐ Caucasian☐ ☐ Other ☐ Pacific Islander ☐ Declined

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

Home Address _____Apt.#_____

City_____State_____Zip_____

Home Phone # _____Cell Phone #_____E mail_____

Communication Preference ☐ Home Phone ☐ Cell 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 _____ FT_____ PT _____

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 # _____