



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 # _____