MONTAGE Medical Group

Patients Name: (Last, First, MI):	SSN: - -	DOB: / /	Circle One: Male Female		
Mailing Address:	Apt. #:	City:	State:	Zip Code:	
Race:	Ethnicity	Primary Language:			
Home Phone: Preferred? □ ( ) -	Cell Phone: Preferred? □ ( ) -	Work Phone: Preferred? □ ( ) -	Email:		
Marital Status: □ Married □ Single□ Domestic Partner □ Other:	Employer:	Occupation:			
Parent/Guardian (if patient is a minor):	Relationship to Patient:	Guarantor Phone: ( ) -	Guarantor SSN: - -		
Address:	Apt #:	City:	State:	Zip Code:	
Emergency Contact:	Relationship:	Home Phone: ( ) -	Cell/Other: ( ) -		
Primary Insurance:	Primary Ins. Group #:	Primary Insurance ID #:			
Subscriber Name(If different from patient)	Subscriber DOB: / /	Relationship to Patient:	Subscriber SSN: - -		
Secondary Insurance:	Secondary Ins. Group #:	Secondary Insurance ID #:			
Subscriber Name(If different from patient)	Subscriber DOB: / /	Relationship to Patient:	Subscriber SSN: - -		
Preferred Local Pharmacy:	Street:	City:			
Preferred Mail Order Pharmacy:	ID:				

Consent to Treat: The information that I have given to Montage Medical Group is complete and true to the best of my knowledge. I authorize the doctors and staff of Montage Medical Group to administer treatment and procedures deemed necessary and that I find agreeable. I understand that Montage Medical Group implies no guarantees of a cure, and that I have the right to choose my treatment options at any time.

Assignment of Benefits: I authorize the release of any medical information necessary to process my insurance billing. I authorize payment of medical benefits to Montage Medical Group.

Lab Service Disclosure: Please be advised that Laboratory Services are provided by Community Hospital of the Monterey Peninsula, Quest, and/or another outside laboratory. If you wish to select a specific laboratory, please inform the medical staff. The lab that receives your specimen(s) will bill you separately for its services.

Use of Cell Phone: I consent to Montage Medical Group, including its business associates, using my cell phone number to call and/or text regarding appointments and to call regarding my care and/or payment of my care. Other federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws

Financial Policy: Montage Medical Group will bill any commercial or governmental insurance on my behalf; however it is my responsibility to know the details of my particular benefit plan. I understand that MMG is required to report (or "code") procedures and diagnoses based on the services I receive; consequently, the coding cannot be changed later to cause the insurance company to pay for a non-covered service as this is considered fraudulent practice. I, the undersigned, agree to pay Montage Medical Group as appropriate, in accordance with regular rates and terms. I also agree that I am overall responsible for the entire balance due on the account, including non-covered services, copayments, co-insurance, deductibles, etc. It is the policy of Montage Medical Group to collect co-payments at the time services are rendered. Private pay patients must pay the total balance due at the time of service. I agree to a $25.00 fee for checks returned for non-sufficient funds.

Signature _____ Date _____

Print Guardian Name (If not patient) _____ Relationship _____

MONTAGE Medical Group

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: _____

Date: _____

Privacy Official, 100 Wilson Rd, Ste 100, Monterey, CA 93940 Phone: (831) 649-1000

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____ **Date:** _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

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I identify the following individuals as being involved in my care and/or payment of my care. I authorize my healthcare provider, or representative, to discuss any healthcare and/or financial information with the following individuals.

Name	**Relationship**	**Phone**

Signed:_____ **Date:** _____

MONTAGE Medical Group

Please complete form to the best of your ability so we can provide you with excellent medical care.

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

Medications	**Dose**	**Frequency**	**Prescribed by**
Example: *Metoprolol*	***Example:*** *25 mg*	***Example:*** *1/2 tablet two times daily*	***Example:*** *Dr. Peninsula*

Allergies: Drug/Medication/Food/Environmental	**Reaction**	**Severity**

Past Medical History

□ Allergies	□ Blood Clots	□ Gallbladder Disease	□ Osteoarthritis
□ Anemia	□ CVA-Stroke	□ Gastric Reflux	□ Osteoporosis
□ Angina	□ COPD	□ Hepatitis C	□ Peptic Ulcer Disease
□ Anxiety	□ Coronary artery disease	□ High Cholesterol	□ Kidney Disease
□ Arthritis	□ Crohn's Disease/Colitis	□ High Blood Pressure	□ Seizure Disorder
□ Asthma	□ Depression	□ Irritable Bowel Disease	□ Thyroid Disease
□ Atrial fibrillation	□ Diabetes	□ Liver Disease	□ Back Pain
□ Benign Prostatic Enlargement		□ Migraine Headaches	□ Other_____
		□ Heart Attack	

Past Surgical History

Surgery	**Year**	**Surgery**	**Year**
□ Heart Surgery	_____	□ Gastric Bypass	_____
□ Appendix Removed	_____	□ Hernia Repair	_____
□ Arthroscopy Knee	_____	□ Hip Replacement	_____
□ Back Surgery	_____	□ Knee Replacement	_____
□ Carpal Tunnel Release	_____	□ LASIK Eye Surgery	_____
□ Cataract	_____	□ Liver Biopsy	_____
□ Gall Bladder	_____	□ Joint or Bone Surgery	_____
□ Bowel Surgery	_____	□ Pacemaker	_____
□ Bladder Surgery	_____	□ Small Bowel Resection	_____
□ Coronary Artery Bypass Graft	_____	□ Thyroid Surgery	_____
□ Other:	_____	□ Tonsils Removed	_____

Gender Specific

Surgery	**Year**
□ Hysterectomy	_____
□ Breast Surgery	_____
□ Tubal Ligation	_____
□ Breast Biopsy	_____
□ Cesarean Section	_____
□ D and C	_____
□ Mastectomy	_____
□ Uterine Surgery	_____
□ Breast Reduction	_____
□ Prostate Surgery	_____
□ Vasectomy	_____
□ Other:	_____

MONTAGE Medical Group

Name: _____ **Date of Birth:** ____/____/____

Please complete form to the best of your ability so we can provide you with excellent medical care.

For Women Only: ***Number of pregnancies:**_____ ***Date of last menstruation:** ___ /___ / ____

Family History			
Relation	**Medical Condition**	**Relation**	**Medical Condition**
Mother		**Maternal Grandmother**	
Father		**Maternal Grandfather**	
Brother		**Paternal Grandmother**	
Sister		**Paternal Grandfather**	
Daughter		**Aunts**	
Son		**Uncles**	

Tobacco Use

Use:	**Type:**	**Years used:**	**Passive smoke exposure:**	**Ever tried to quit:**
□ Current	□ Cigarettes			□ Yes
□ Former	□ Cigar	**Pack(s) per day:**	□ Yes	□ No
□ Never	□ Other:		□ No	**Longest Tobacco free:**

Alcohol

□ **No** □ **Yes** If yes, type: **Amount:** **Per:** □Day □Week □Socially □Other

Caffeine/Drugs/Exercise

Caffeine: □ Yes □ No **Drinks per day:** _____ **Type:** _____

Drugs: □ Yes □ No **Type:** _____ **Frequency:** _____

Exercise: □ Yes □ No **Type:** _____ **Frequency:** _____

Routine Health Maintenance: What was the date of your last:

Bone Density	*Cardiac Test*	*Colonoscopy*	*Fasting Lab*	*Last Physical*	*Mammogram*	*Pap Smear*

Immunizations/Vaccines							
Name	*Tetanus/Tdap*	*Hep A/B*	*Hib*	*HPV*	*Flu*	*MMR*	*Meningococcal*
Date							
Name	*Pneumonia*	*Polio*	*Varicella*	*Zoster*	*Other:*	*Other:*	*Other:*
Date							

MONTAGE Medical Group

Name: _____ **Date of Birth:** ____/____/____

Please complete form to the best of your ability so we can provide you with excellent medical care.

Do you have any of the following? (Check all that apply) **You may request information if desired.**
□ **Living Will** □ **Health Proxy** □ **POLST** (Physician Order for Life Sustaining Treatment)
I would like more information about an Advance Directive □ Yes □ No, not at this time

Specialists/Other Healthcare Providers		
Doctor's Name	**Specialty**	**City**

Please let us know how you heard about us or who referred you to our clinic:
□Website □Family/Friend □Advertisement □Physician Referral: Name: _____
□Other _____

I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Print Guardian Name (If not patient) Relationship