Patients Name: (Last, First, MI):	DOB: / /	SSN: - -	Circle One: Male Female
Mailing Address:	Apt. #:	City: State:	Zip Code:
Driver's Lic or ID #:	How would you like to be contacted for appointment reminders? □ Telephone Call □ Email		

Home Phone: Preferred? □ ( ) -	Cell Phone: Preferred? □ ( ) -	Work Phone: Preferred? □ ( ) -	Email:

Race:	Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino	Primary Language:
Occupation:	Employer:	Marital Status: □ Married □ Single □ Domestic Partner □ Other:

Parent/Guardian (if patient is a minor):	Relationship to Patient:	Guarantor Phone: ( ) -	Guarantor SSN: - -
Address:	Apt #:	City:	State: Zip Code:
Emergency Contact 1:	Relationship:	Home Phone: ( ) -	Cell/Other: ( ) -
Emergency Contact 2:	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.

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 PPC 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:** ____/____/____

Height: ____________ **Weight**: ____________

Have you gained or lost weight in the last six months? Y N

If yes, estimate how much: ______ lost ______ gained

What would you like to weigh? _________ lbs. Are you on a special diet? Y N

If yes, please describe: ____

Specialists/Other Healthcare Providers	Specialty	City, State, Phone
	Primary Care Physician	
	Dentist	

Allergies: Drug/Medication/Food/Environmental	Reaction	Severity

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

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

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

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Medical Group

Cardiovascular History			
Have you ever been told that you've had a heart attack?	Y N	Have you ever been told that you have high blood pressure?	Y N
Do you ever have pain, tightness, or discomfort in your chest or arms?	Y N	When did you first take medication for high blood pressure (Year)?	______
Do you have palpitations or skipped heart beats?	Y N	Have you ever had rheumatic fever?	Y N
Have you fainted or passed out in the last year?	Y N	Have you ever been told that you had a heart murmur?	Y N
Do you have difficulty breathing?	Y N	Have you ever been told that your cholesterol, lipid, or triglyceride level is elevated?	Y N
Do your ankles swell up?	Y N		
Do you find physical effort more exhausting now than previously?	Y N		

Past Medical History

Condition	Year Diagnosed	Condition	Year Diagnosed	Condition	Year Diagnosed
☐ Anemia	__________	☐ Diverticulitis	__________	☐ Leukemia	__________
☐ Arthritis	__________	☐ Easy Bruising	__________	☐ Numbness	__________
☐ Asthma	__________	☐ Emphysema	__________	☐ Pancreatitis	__________
☐ Bladder Infection	__________	☐ Fractures	__________	☐ Paralysis	__________
☐ Bleeding	__________	☐ Gout	__________	☐ Pneumonia	__________
☐ Blood in Urine	__________	☐ Heart Burn	__________	☐ Poor Appetite	__________
☐ Blindness	__________	☐ Hepatitis	__________	☐ Severe Vomiting	__________
☐ Blood in Sputum	__________	☐ Hiatal Hernia	__________	☐ Shortness of Breath	__________
☐ Bronchitis	__________	☐ High Blood Sugar	__________	☐ Stomach Ulcer	__________
☐ Constipation	__________	☐ Indigestion	__________	☐ Stroke	__________
☐ Cough	__________	☐ Jaundice	__________	☐ Thyroid Problem	__________
☐ Diabetes	__________	☐ Joint Pain	__________	☐ Tumor Growth	__________
☐ Diarrhea	__________	☐ Kidney Stone	__________	☐ Weight Loss	__________
☐ Disk, Back or Spine Disease	__________				

Past Surgical History

Condition	Year Diagnosed	Condition	Year Diagnosed	Condition	Year Diagnosed
☐ Heart Surgery	_________	☐ Gastric Bypass	_________	☐ Hysterectomy	_________
☐ Appendix Removed	_________	☐ Hernia Repair	_________	☐ Breast Surgery	_________
☐ Arthroscopy Knee	_________	☐ Hip Replacement	_________	☐ Tubal Ligation	_________
☐ Back Surgery	_________	☐ Knee Replacement	_________	☐ Breast Biopsy	_________
☐ Carpal Tunnel Release	_________	☐ LASIK Eye Surgery	_________	☐ Cesarean Section	_________
☐ Cataract	_________	☐ Liver Biopsy	_________	☐ D and C	_________
☐ Gall Bladder	_________	☐ Joint or Bone Surgery	_________	☐ Mastectomy	_________
☐ Bowel Surgery	_________	☐ Pacemaker	_________	☐ Uterine Surgery	_________
☐ Bladder Surgery	_________	☐ Small Bowel Resection	_________	☐ Breast Reduction	_________
☐ Coronary Artery Bypass Graft	_________	☐ Tonsils Removed	_________	☐ Prostate Surgery	_________
☐ Thyroid Surgery	_________			☐ Vasectomy	_________
				☐ Other:	_________

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

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

Hospitalizations

MONTAGE Medical Group

Date	Medical Condition Treated	Hospital Name, City, State

Family History					
Relation	**Medical Condition**	**Age/Cause of Death?**	**Relation**	**Medical Condition**	**Age/Cause of Death?**
Mother			**Maternal Grandmother**		
Father			**Maternal Grandfather**		
Brother			**Paternal Grandmother**		
Sister			**Paternal Grandfather**		
Daughter			**Aunts**		
Son			**Uncles**		

Social History			
Children: □ None # Boys: _____ # Girls: _____	**Military Experience:** □ Yes □ No	***For Women Only*:** Number of pregnancies:_____ Number of births: _____ Date of last menstruation: ______/______/______	**Highest Level of Education:** ____________________

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

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

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

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Immunizations/Vaccines				
Name	*Tetanus/Tdap*	*Pneumonia*	*Zoster*	*Flu*
Date				

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

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