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:** ____/____/____

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*

Gynecologic History

Last Menstrual Period: _____ **Normal:** □ Yes □ No **If not, why?:** _____

Contraception: □ Yes □ No **Type:** _____ **Pleased with current contraception?:**□ Yes □ No
If not, why?_____ **Prior forms:** _____

Sexually Active: □ Yes □ No **Partner:** □ Male □ Female **Monogamous:** □ Yes □ No

History of abnormal PAP: □ Yes □ No **When:** _____ **Treatment:** _____

History of Sexually Transmitted Infection: □ Yes □ No **Type:** _____
Treatment: _____ **Current Symptoms:** _____

Obstetric History

How many pregnancies total?: ___ **Term:** _____ **Pre-Term:** _____
Miscarriages: _____ **Terminations:** _____ **Ectopics:** _____
Number of living children: ___

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

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

Past Surgical History				**Gender Specific**	
Surgery	**Year**	**Surgery**	**Year**	**Surgery**	**Year**
□ 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	_____	□ Thyroid Surgery	_____	□ Prostate Surgery	_____
□ Other:	_____	□ Tonsils Removed	_____	□ Vasectomy	_____
				□ Other:	_____

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

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

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

Marital Status/Family/Employment			
Current status: □ Married □ Single □ Divorced □ Widowed □ Life partner □ Other:	**Children:** □ None □ Yes # Boys: _____ # Girls: _____	**Military Experience:** □ Yes □ No	**Occupation:** _____ **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:**

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

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

Immunizations/Vaccines

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

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