

MONTES MEDICAL GROUP, INC.

Patient Registration

PRIMARY LANGUAGE: English Spanish Other _____

Interpreter Services Offered: Yes No

HEARING IMPAIRED: Yes No

PATIENT DEMOGRAPHIC INFORMATION

Name: _____
Last Name First Name Middle Name

Address: _____
Number Street City State Zip Code

Home Telephone: _____ Social Security #: _____

Place of Birth: _____ Date of Birth: _____ Age: _____ Gender: _____

Drivers License #: _____ Email Address: _____ No Email

Married: Spouse Name _____ Single Separated Divorced Widowed

PATIENT EMPLOYER INFORMATION

Name of Employer: _____ Telephone #: _____

Address: _____
Number Street City State Zip Code

Occupation: _____ Length of Employment: _____

Name of Insurance Co.: _____ Policy #: _____ HMO PPO

Medi-Cal #: _____ Medi-Care #: _____

PRIMARY INSURANCE SUBSCRIBER INFORMATION

Name: _____ Soc. Sec. #: _____ Date of Birth: _____

Address: _____
Number Street City State Zip Code

Employer Name: _____ Telephone: _____

Address: _____
Number Street City State Zip Code

Name of Insurance Co.: _____ Policy #: _____ HMO PPO

Medi-Cal #: _____ Medi-Care #: _____

EMERGENCY CONTACT NOT LIVING WITH YOU

Name: _____ Relationship: _____ Telephone: _____

Address: _____

Please Return Completed Form to Receptionist. Thank You.

MONTES MEDICAL GROUP, INC.

General Acknowledgment Form

General Consent

I hereby request and consent to diagnostic procedures, tests, and medical treatment, including immunizations, deemed advisable by a health care provider at Montes Medical Group, Inc.

I further authorize Montes Medical Group, Inc. to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also, Montes Medical Group, Inc. may use and release any part of my record necessary for processing or billing third party payors for services rendered on my behalf.

- Patient/Responsible Party Initials _____

Acceptance of Financial Responsibility

As a courtesy, Montes Medical Group will bill your insurance directly (where applicable). By signing below you agree to accept financial responsibility for products, services, or procedures not covered or paid by your health plan.

- Patient/Responsible Party Initials _____

Advance Directives Acknowledgment

I acknowledge that I have received and reviewed Montes Medical Group, Inc's *Advance Directives* handouts.*

- * *The handout recommends that you keep on file with your primary care physician a copy of your completed Advance Directives. Please speak with our receptionist if you would like an Advance Directives form to fill out.*

- Patient/Responsible Party Initials _____

Patient Acknowledgment

I acknowledge that I have reviewed and agree to Montes Medical Group, Inc's

1. *General Consent* policy,
2. *Acceptance of Financial Responsibility* policy,
3. *Advance Directives* handout, and
4. *Notice of Privacy Practices* handout.

Patient / Responsible Party Printed Name

Patient / Responsible Party Signature

Date