

# MONTES MEDICAL GROUP, INC.

## Patient Registration

**PRIMARY LANGUAGE:**  English  Spanish  Other \_\_\_\_\_

Interpreter Services Offered:  Yes  No

**HEARING IMPAIRED:**  Yes  No

Parent/Legal Guardian: \_\_\_\_\_  
Last Name First Name Middle Name

### PATIENT DEMOGRAPHIC INFORMATION

Patient: \_\_\_\_\_  
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 # (if applicable): \_\_\_\_\_ Mother First Name \_\_\_\_\_ Mother Maiden Name \_\_\_\_\_

Email : \_\_\_\_\_ This Email is for the  Patient, or  Parent / Legal Guardian .

### 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.

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## 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.

- Parent / Legal Guardian Initials \_\_\_\_\_

### Minor Consent for Treatment & Disclosure of Patient's Medical Information

Montes Medical Group takes your child's safety very seriously. We will not examine your child unless an authorized adult is present during the exam. If you would like to allow an adult aside from the parent or legal guardian to accompany your child to an exam, please complete a Minor Consent for Treatment Form available from our receptionist.

In addition, the parents of a child normally have the right to view the child's medical record. If you, as a custodial parent, would like to prevent a non-custodial parent from accessing your child's record, you must submit this request in writing along with a copy of the official declaration of legal guardianship provided by the court.

- Parent / Legal Guardian 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.

- Parent / Legal Guardian Initials \_\_\_\_\_

### Acknowledgment

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

1. *General Consent* policy,
2. *Minor Consent for Treatment & Disclosure of Patient's Medical Information* policies,
3. *Acceptance of Financial Responsibility* policy, and
4. *Notice of Privacy Practices* handout.

\_\_\_\_\_  
Parent / Legal Guardian Printed Name

\_\_\_\_\_  
Parent / Legal Guardian Signature

\_\_\_\_\_  
Date