MONTES MEDICAL GROUP, INC.

Patient Registration

Primary language ☐ English ☐ Spanish Other _____

Are you hearing impaired? ☐ Yes ☐ No Translator assistance requested ☐ Yes ☐ No

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ (Last) _____ (First) _____ (Middle)

Mailing Address: _____ (Street Number & Name) _____ (Apt. #) _____ (City, State, Zip)

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: _____

Drivers License #: _____ Social Security #: _____

Race: ☐ American Indian / Alaska Native ☐ Black or African American ☐ Hispanic

☐ Native Hawaiian ☐ Asian ☐ Other Race

☐ Other Pacific Islander ☐ White ☐ Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report

For patients 18 years and under:

To enroll in the California Immunization Registry, please provide the patient's mother's first name and maiden name:

Mother's First Name: **Mother's Maiden Name:**

PRIMARY INSURANCE INFORMATION

Insurance Co. Name _____ ☐ HMO ☐ PPO

Subscriber ID #: _____ Group #: _____

SUBSCRIBER INFORMATION ☐ Mark here if self-insured and skip to next section.

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

Address: _____ Pref. Phone _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name _____ ☐ HMO ☐ PPO

Subscriber ID #: _____ Group #: _____

SUBSCRIBER INFORMATION ☐ Mark here if self-insured and skip to next section.

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

Address: _____ Pref. Phone _____

RESPONSIBLE PARTY INFORMATION (IF APPLICABLE)

If patient is a minor, please list the information for the patient's parent(s) or legal guardian(s).

If patient is over 18 with a legally designated caregiver, please list caregiver's name.

1. _____ (Name) _____ (Date of Birth) _____ (Preferred Phone) _____ (Relation to Patient)

2. _____ (Name) _____ (Date of Birth) _____ (Preferred Phone) _____ (Relation to Patient)

EMERGENCY CONTACT NOT LIVING WITH YOU

_____ (Name) _____ (Relationship) _____ (Primary Phone)

_____ (Address) _____ (Secondary Phone)

MONTES MEDICAL GROUP, INC.

General Acknowledgment Form

GENERAL CONSENT
I hereby request and consent to diagnostic procedures, tests, and medical treatments, including immunizations, deemed advisable by a healthcare 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.

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.

PRESCRIPTION & MEDICATION HISTORY
To ensure that we do not prescribe medications that might have a harmful interaction with another medication you may be taking, we ask that you allow us to review your external prescription information and medication history.

I hereby authorize Montes Medical Group, Inc. to obtain my previous prescription and medication history through external sources. ***Please initial: _____***

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have reviewed and agree to Montes Medical Group, Inc.'s *Notice of Privacy Practices* handout.

FOR PATIENTS 18 YEARS AND OLDER

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

It is recommended that all patients over 18 years old keep on file with Montes Medical Group, Inc. a copy of your completed Advance Directives. Please speak with our receptionist if you would like an Advance Directive form to fill out.

FOR PATIENTS UNDER 18 YEARS

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 a parent, legal guardian, or 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, please write a detailed letter including the name of the patient, the date of service, and the name of the authorized adult and send with the authorized adult to present at the visit. All letters must be signed and dated.

In addition, both 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.

PATIENT / RESPONSIBLE PARTY SIGNATURE		
I acknowledge that I have reviewed and consent to the policies explained and referenced above.		
Signature	Printed Name	Date

MONTES MEDICAL GROUP, INC.

General Acknowledgment Form

PREFERRED PHARMACY

Please designate a preferred pharmacy to assist our providers in submitting your prescriptions.

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Street Number & Name, City, State, & Zip Code

We can look up the address if you are unsure. Please provide the nearest major cross streets.

_____

INTERNET ENABLED COMMUNICATION

- *RECEIVE COMPANY NEWS AND HEALTH ANNOUNCEMENTS BY EMAIL*

  Montes Medical Group and/or its subsidiaries may occasionally send out company news and announcements by email. Possible topics of these emails might include health fairs and company events available to our patients, the addition of a new physician or physician assistant, newly available services, or new health recommendations.

- *ESTABLISH A PATIENT PORTAL ACCOUNT*

  Montes Medical Group now offers our patients easy and private access to their medical information online, so you can view your personal health record whenever and wherever you have access to the Internet.

  Gain access to your private health information and receive clinical updates and reminders from your doctor on your secured patient portal account.

  By including your email address below, you agree to allow Montes Medical Group and/or its subsidiaries to send you company news and information by email, and you agree to allow a Montes Medical Group representative to establish a patient portal account on your behalf.

  My email address is: _____

  This email address belongs to the

  ☐ Patient

  ☐ Parent/Legal Guardian. Parent/Legal Guardian name: _____

CELL PHONE COMMUNICATION

I authorize Montes Medical Group (MMG) to send text messages to my cell phone to convey important information. No personal health information will be included. I understand that standard text messaging rates will apply to any messages received from MMG. I agree not to hold MMG liable for any electronic messaging charges or fees generated by this service. I also understand that I may revoke this permission in writing at any time at my local MMG office.

Yes! I agree to receive text message communication from Montes Medical Group: _____

Please Initial

MONTES MEDICAL GROUP, INC.

AUTHORIZATION TO ALLOW DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____ Name: _____ DOB: _____

I, _____ authorize the following individual(s) to receive any and all information regarding my medical care. I understand that this authorization will be in effect until revoked by me in writing.

	Name	DOB	Relationship	Driver's License/ State ID Number (optional)
1				
2				
3				

If patient is unable to sign, documentation from legal custodian is required.

Signature of Patient\Legal Custodian: _____

Name of Legal Custodian (if applicable): _____

. The witness must not be an individual named above.

Signature of Witness: _____

Name of Witness: _____

For Montes Medical Group use only:

Name of MMG employee that verified the identity of the patient: _____

Information entered into eCW system on _____ (Date) by _____ (Name)