Altos Oaks Medical Group
2485 Hospital Dr., Suite 330
Mountain View, CA 94040
Phone: 650-988-7470
Fax: 650-988-7472

Last Name_______________________________ First Name _______________________ Middle______________________

Maiden Name_____________________ Date of Birth____________________ Sex _________ SS_____________________

Street Address __________________________________ City___________________ State________ Zip_______________

Primary Phone #_______________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? ________

Secondary Phone #_____________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? ________

Email Address____

Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email ☐ MyChart

May we mail normal result letters and appointment reminders to you? ☐ Yes ☐ No

Appointment Reminder Opt-in Preference: ☐ Email ☐ Phone ☐ Text Message ☐ Decline

Preferred Language_____________________________________ Do you need an interpreter? ☐ Yes ☐ No

Religious Preference_____________________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Other ☐ Decline to disclose

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African American ☐ Caucasian
☐ Other ☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Disclose

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Single ☐ Widowed

Significant Other Last Name___________________________ First Name ____________________ Sex_____ DOB _________

Primary Phone # ______________________________ Secondary Phone # ____

Primary Care Provider Last Name____________________________ First Name_____________________________________

Street_________________________ City_______________ State_______ Phone________________ Fax_______________

Referring Provider Last Name_______________________________ First Name ____

Street__________________________ City______________ State________ Phone_______________ Fax______________

Preferred Pharmacy Name ____________________________________ Phone #___________________________________

Street Address ____________________________ City_______________ State_______ Zip___________________________

Employer Name_____________________________________ Occupation____

Street Address____________________________ City________________ State____________ Phone__________________

Emergency Contact 1 Last Name_______________________________ First Name___________________________________

Street Address_____________________________ City ________________ State_________ Zip ______________________

Primary Phone #_____________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Secondary Phone #___________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Language ____ Does this contact require an interpreter? ______________

Relationship to you ____

Emergency Contact 2 Last Name_______________________________ First Name___________________________________

Street Address__________________________ City __________________ State_________ Zip _______________________

Primary Phone #_____________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Secondary Phone #___________________________ ☐ Mobile ☐ Home ☐ Work May we leave a message? _________

Language ____ Does this contact require an interpreter? ____________

Relationship to you____

Guarantor Information

Last Name_______________________________ First Name _________________________ Middle______________________

Date of Birth_________________ Sex __________ SS______________________ Phone #_______________________________

Updated 12.3.2014

Street Address ____________________________________ City____________________ State________ Zip_________________

Employer Name____ Occupation ______________________________________

Street Address ______________________________ City________________ State______ Phone #_________________________

Health Coverage Details

1. **Primary Coverage** _____________________________________ Auth Phone #_________________________________

Claim Address ____________________________________ City____________________ State________ Zip_________________

Name on Card: ____

Member relationship to the subscriber: _________________ Member ID #:___________________ Effective Date: __________

Subscriber's Last Name___________________________ First Name ______________________ Sex_____ DOB_____________

Street Address ____________________________________ City____________________ State________ Zip_________________

Subscriber ID #:___________________ Group #:_______________________ Group Name: ____________________________

2. **Secondary Coverage** _____________________________________ Auth Phone #_________________________________

Claim Address ____________________________________ City____________________ State________ Zip_________________

Name on Card: ____

Member relationship to the subscriber: _________________ Member ID #:___________________ Effective Date: __________

Subscriber's Last Name___________________________ First Name ______________________ Sex_____ DOB_____________

Street Address ____________________________________ City____________________ State________ Zip_________________

Subscriber ID #:___________________ Group #:_______________________ Group Name: ____________________________

Printed Name: ____

Signature: ____ Date:_____________________

Updated 12.3.2014