



Altos Oaks Medical Group
2485 Hospital Dr., Suite 330
Mountain View, CA 94040
Phone: 408-988-7470
Fax: 408-988-7472

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 #** _____



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: _____