Altos Oaks Medical Group
2495 Hospital Dr., Suite 625
Mountain View, CA 94040
Phone: 650-988-7470
Fax: 650-725-7253

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 #_____

Stanford Children's Health

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:_____