Monterey Peninsula Pediatric Medical Group

PATIENTS 18 YRS AND OLDER

PATIENT INFORMATION:

Name (First)_____(M.I.)____(Last)_____Preferred Name_____

Address_____ City / State / Zip_____

Date of Birth_____ Age_____ Gender: ___ Male ___ Female

Cell number _____ Preferred Language English ___ Other_____

Patient email _____

Emergency Contact 1. _____Phone_____Relationship _____

Emergency Contact 2. _____Phone_____Relationship _____

MEDICAL RECORD CONSENT

I understand that by law 18 year olds are adults and they have the legal right to keep health records confidential. Now that I am 18, I am authorizing the following people to have access to my medical records. I understand that I may revoke this consent at any time by giving written notice to MPPMG.

Name_____Relationship to Patient_____

Name _____ Relationship to Patient_____

RESPONSBILE PARTY/ BILLING INFORMATION (If different than Patient):

Name_____ Relationship to Patient _____

Address_____ City / State / Zip_____

Cell number _____ Home number _____

H.I.P.A.A. NOTIFICATION

I acknowledge receipt of Monterey Peninsula Pediatric Medical Group's notice of Privacy Practice and Patients' Rights effective 8/15/2018.

Patient Signature_____ Date_____

CONSENT TO EXAM AND TREATMENT

I give consent to be treated by Monterey Peninsula Pediatric Medical Group and its associates. The above information is accurate and complete to the best of my knowledge.

Patient Signature_____ Date_____