PHYSICIANS MEDICAL GROUP OF SAN JOSE

EXCEL MSO, LLC
ADVANCED HEALTH CARE SOLUTIONS

Pre-Application Questionnaire

Demographics:

Full Name:	**Degree:**	**Years in Practice:**
Primary Office Address: _____ *Street* *Suite* _____ *City* *State* *Zip*	**Hours:** **Phone(s):**	
Secondary Office Address: _____ *Street* *Suite* _____ *City* *State* *Zip*	**Hours:** **Phone(s):**	

Practice Information:

1. What patient population are you willing to see? **(*PMGSJ requires all Specialists to accept the following types of plans)**
☐ HMO Commercial ☐ SCFHP- Medi-Cal ☐ Blue Cross - Medi-Cal ☐ Medicare Advantage ☐ PPO ☐ Cal Medi-Connect ☐ Workers Compensation

2. I practice as a ☐ Primary Care Physician OR ☐ Specialist

3. I am Board Certified in:

a.	b.	c.

4. I want to practice under the following specialties:

a.	b.	c.

5. Languages spoken by you: Languages spoken by your staff:

6. I own my own practice? ☐ Yes (if yes go to #9) ☐ No

7. I share office space with other provider(s) who are not a group? ☐ Yes ☐ No

a. Please list other provider(s):

8. I belong to a group? ☐ Yes ☐ No ☐ Owner of group (if applicable)?

a. The name of the group is *(Attach a list of members)*:

b. What is your relationship with the group?
☐ Employer/employee relationship ☐ Partner/share ownership ☐ Share expenses of the practice
☐ Share office ☐ On-call only ☐ Other (explain):
_____

9. I have hospital privileges at:
☐ El Camino Hospital Mtn. View ☐ Good Samaritan ☐ O'Connor ☐ Regional Medical Center
☐ El Camino Hospital Los Gatos ☐ St. Louise ☐ Santa Clara Valley Medical Center
☐ Other: _____ ☐ Stanford/LP

10. I have privileges at the following ambulatory surgical center:
☐ Advanced Surgery Center ☐ Bascom Surgery Center ☐ El Camino Surgery Center
☐ Montpelier Surgery Center ☐ Forest Surgery Center

*PLEASE FAX COMPLETED PRE-APPLICATION QUESTIONNAIRE AND CV TO 408-937-3639 ATTN: PROVIDER SERVICES

Other: _____
11. Any malpractice history, board, license or any other disciplinary actions? ☐ No ☐ Yes, provide details
12. Do you have an EMR? ☐ No, If you are approved to join Physicians Medical Group of San Jose, we ask that you begin utilizing EMR. ☐ Yes, Name of EMR: _____
Signature: _____ Date: _____

*PLEASE FAX COMPLETED PRE-APPLICATION QUESTIONNAIRE AND CV TO 408-937-3639 ATTN: PROVIDER SERVICES