

1020 S. 8th Street • Deming, NM 88030 Ph. (575)936-4350 • Fax (575)-936-4351 Afterhours/Emergency Number: (575) 545-3985

	NEW PATIENT	REGISTRATION FORM	
atient Information	LESSON OF WEST TRIBY FROM	Middle Name Initial:	Date of birth:
irst Name:	Last Name:	c I	1
Address:		I. T.	Mobile number:
Address.			Home Number:
City:	State:	Zip code:	() - was phase of the first of
	reservative Prigramacy:	Email address:	Name:
Other names used:		Email address.	
			10.20 p. 10.
Gender:	Social Security Number:	Preferred language:	Driver's License #:
M F	(estament Pro	N CONTRACTOR SECURITION	200000000000000000000000000000000000000
Marital status:	Preferred contact:	Ethnicity:	Race: American Indian or
☐ Married	☐ Mail	Refuse to answer	American Indian or Alaskan
□ Single	□ Email	☐ Hispanic/Latino	and the second s
☐ Divorced	Phone	□ Non-Hispanic	Committee of the commit
□ Separate		A second property of the second property of t	☐ Asian ☐ Native Hawaiian/other
□ Widower			pacific
☐ Life partner	the state of the same of the s		White
	and the same of th	and the second s	Other
		5 L Address	Employer Phone:
Occupation:	Employer Name:	Employer Address:	() -
		Contraction of the Contraction o	
Person Responsible (Guarant First Name:	Last Name:	Middle name initial:	Date of birth:
FIISt Name.	S C C C C C C C C C C C C C C C C C C C	and the second of the second o	500 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Address:			Mobile number:
Additional No. 104 (all and the second trees of the second tred trees of the second trees of the second trees of the second tr		- Committee - Comm	Home Number:
City:	State:	Zip code:	() -
S. J. I. C Numbers	Preferred language:	Driver's License #:	Relationship to the patient:
Social Security Number:	ocial Security Number: Preferred language:		
Emergency Contact			
First Name:	Last Name:	Middle name initial:	Date of birth:
	neutro - otto	1031	Mobile number:
Address:			() -
City:	State: longituding delit	Zip code:	Relationship to the Patient:
between the control of the control o	smoothnys is und aldstiru		EII SAA
Primary Insurance	mancair measure Northead solutions		Relationship to the Patient:
Insurance company:	Name of policyholder:	Date of birth:	Relationship to the Patient.
The second secon	Address to chlores		Strate chief Variant.
Policy Number:	Liver province	Group number:	emedita-
Secondary Insurance			101496
Insurance company:	Name of policyholder:	Date of birth:	Relationship to the Patient:
moditative company.	zkanogostat		Bleading/clotting
the state of the s	a contract of	Croup number:	Digensity's le
Policy Number:		Group number:	

Website: www.swpedscare.com



1020 S. 8th Street • Deming, NM 88030 Ph. (575)936-4350 • Fax (575)-936-4351 Afterhours/Emergency Number: (575) 545-3985

		NEW PAT	TIENT	HISTORY		
Reason for the visit:	No health probl					
1.	1.					emsti ta
3. เอนเกษา อกับเหต		And the property of the second section of the		2.		- 2011 EDS. 1 32
Pharmacy Information				4.	1 1 1 1 1 1 1 1 1 1	1016221
Primary Pharmacy:		ra Se z qui				
Name:				Secondary Pharmacy:		<u> </u>
Address:		Email address:		Name:		ther names used:
Advanced Directives			,	Address:	7-7-	THE STATE OF THE S
□ None □ Do Not	□ Power	of Attorney		To a second policy to the		
resurrect			☐ Testament ☐ Proxy to make decisions			
Drug List- Lists all medications you ta	ke, prescription	and over-the-c	count	er.		
☐ I do not take medication	onits Nation	teres (L.)				
Name of the drug	Hispanic	How many tim	nes a	day enode	Dosage	elani? :
1. ORISA G				enone	Dosage	Divorced
2. STOCK TEREWER SYLERY						SEPSECE
3. atidiki						19WODAW
4. Other						
Employer Phone:	1229	Employer Addi		to avoid the second		The second secon
6.		reason is an I confirm		imployer Name:		occupation:
7.					de Confession	GIFTONIA WINE PROPERTY
8.	.103311	smen sibbitor		- 2011/1971 3 (4)		
Drug and Food Allergies-Lists all know	n allergies (me	dication, food, a	anima	als. etc.)		
No known allergies				,,		Sand Artic
1. деатий этон		Zip cede:	3.	51312°		(VIII)
Relationship to the patient:	12 12	Driver's Licens	4.	- Constant Land Land		Comment to the control of the contro
5.	AND A STANDARD STANDA			Preferred language	7190	Societ Security Numb
Medical History- Check mark if you ha	ve ever experie	nced the follow	ing c	anditions and the year		mathad lone ji ma
Condition			₆ c			249 449 7219
None		Year		Condition		Year
Acid reflux to a girlanoitalan		Zio code:		High blood pressure High cholesterol		
Anemia		Taboo ena		Irritable bowel syndrome		(VIV)
Angina				Arrhythmia/palpitations		Paradity Insufance
Anorexia/bulimia		Date of birth.		Joint problems	and the real control of the second se	gesatts assessment insurance company
Anxiety/panic attacks				Kidney problems		
Arthritis	- 1	Group number		Liver problems	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Policy Number:
Asthma				Migranas/headaches		Control of the second s
Atrial fibrillation and another A		Date of birth:		Mobility problems		Secretary Control
Bleeding/clotting		The same and address of		Osteoporosis		insurance company
Bronchitis		Martin Committee Com		Pneumonia		
Cancer- (Type:)	Group transpe		Psychiatric problems		Policy Number
Dependence on drugs/alcohol				Prostate problems		
COPD/emphysema			☐ Enviromental allergies			
Crohn's disease			☐ Sexually transmitted disease			
				,		

Website: www.swpedscare.com



1020 S. 8th Street • Deming, NM 88030 Ph. (575)936-4350 • Fax (575)-936-4351 Afterhours/Emergency Number: (575) 545-3985

Dementi	a/Alzheimer's				atology condition		Theyed year
Depressi	TO A STATE OF THE PARTY OF THE	ny A yn	BM WUF .	□ Strok	The second secon	Normal Control of the	cost a second
Diabetes		The state of the state of the state of		☐ Seizures/epilepsy			26.1.0.25
Gout	501 W.	28	9.3	☐ Thyroid disease		NAME OF TAXABLE	VACEAUTY STATE
Cholecys	titis			☐ Tonsi			and the second
	ogy problems			☐ Tube			
	sease/heart attack			□ Ulcer	'S	11	2-1V2
Hepatiti	CONTRACTOR OF THE PROPERTY OF	1		☐ Urina	ary problems	(In Orange Orange)	National Ing. C.
Other:_	**************************************			□ Othe	r:		aproximal -
	ory- Mark or list all surgion	cal procedures and	d year			tis.	
	Surgical procedure	NAME OF THE PARTY	Year		Surgical procedure		Year
None	mode and because the second of the second	and the second s	and the second			The state of the state of	6015
Only Male	100	and X asymptotics	4	introduced in the	Vigorous		Maderite
	surgery			□ Vase	ctomy	The state of the s	and the second
nly Female				75 yrs, 17.0	iif		March 19
Augmer	ntation mammoplasty				tectomy	Provision I	The state of the state of
Tubal li	gation				mectomymia	(NOIZ)	ALECS MALL A TOTAL OF
Breast l			plant of the		uction mammoplasty		Maria de la contra del la contra de la contra de la contra del la contra del la contra de la contra de la contra del la contra del la contra de la contra de la contra del la
	Caesarean section			☐ Abdominal hysterectomy			The sea of the season of the s
Dilation	AND DESCRIPTION OF THE PARTY OF		1.1	□ Vaginal Hysterectomy		The LAST 48	TI STRAIL CONTRACT
Hystere	ctomy	manus com series and a series			hand the second of the second	The second second	
Other:							
			2.				
3.			4.				
5.				6.			1 2-1
7.			8.				
9.			10.				
	enitalizations						
	spitalizations Reason	Hospita	l name	Year	Reason	Но	spital name
Year		Trospita					
			April 10 may				
Health Mai	ntenance- Check if you've	e received the foll	owing tests	and the date			
	Test Date		Test			Date	
□ None				☐ Gynecological exam			
Breast	exam			☐ Influenza vaccine			
	c stress test			☐ Lipid	☐ Lipid panel		
				☐ Mammogram			
				☐ Pap test			
	Density (DEXA scan)				ical exam		
	ardiogram				mococcal vaccine		
	ocardiogram		New York of The State of The St				
☐ Eye ex					ometry		
□ Blood	hidden in stool				oidoscopy		Control of the second
☐ Foot €	Foot exam		□ Tetnus vaccine				

Website: www.swpedscare.com



1020 S. 8th Street • Deming, NM 88030 Ph. (575)936-4350 • Fax (575)-936-4351 Afterhours/Emergency Number: (575) 545-3985

Social/personal backgrou	ınd	The state of the s					
Do you have children?	Yes	No	okou2 mil	How many?	Female:	Male:	
Tobacco Use		No metion of the	outrin?			Depressional	
None Previously/ Year You Smoking:	Stopped	☐ Daily # of Cigars/da	□ Weekly ay:	/ Less	Chew Cigar Other:	Pipe Cigarette	
Alcohol Use			18.3	The control of the second control of the second of the sec		alderg geolegismy?	
NonePreviously/ Year YouDrinking:	Quit	□ Daily # of Drinks/we	□ Weekly	Less	Beer Liquor	Wine Other:	
Recreational Drugs				to so box est.	potential annual services as		
None	☐ History o	f injectable drug	S		revious/current use pecify:	Supple States	
Exercise						onest p	
□ Moderate	□ Vigorou	S	Seden	tary #	Days / week :	Only life le	
Sleep Pattern		Vmo).	DBSSV LIT		recoverage regularization and relative resolution by the contract of the contr	Prostate surgery	
☐ Changes Specify:		1 □ setomy	No Changes		vizslermo	Galy Female Augmentation ma	
Caffeine Consumption		nectornymia	noyM a			noiteal lastion	
None # of drinks/weekl:		ction mammylia minal hysterect		□ Weekly	□ Less	S Breast blopsy Caesardan section	
Have you had a fall in the I	ast year?	al insterectomy	Yes	□ No	AND AND DESCRIPTION OF THE PROPERTY OF THE PRO	Dilation and curet	

Website: www.swpedscare.com



1020 S. 8th Street • Deming, NM 88030 Ph. (575)936-4350 • Fax (575)-936-4351 Afterhours/Emergency Number: (575) 545-3985

Medical Photo Consent Form

Patient Name:	DOB	:/		
(First) (Last)				
I, patient/guardian, consent of medical images ar		video be	eing ma	de.
I agree that the images may be (please check b	below	to show	v conse	ent)
		Yes		No
 placed in the health record for identity protect 	tion	-	_	
 electronically e-mailed to any treating health professional 		ile sees	or orbital	inedin
 used by health professionals for education an 	nd	Mailton.	1363 YJR	i <u>0</u>
training purposes				
By signing below, I confirm that I understand this co	nsent f	orm		
Name of Patient/Guardian:				
(Print)				
is mages syverethe of printing in white proverse easy of the last section of the contract of the section of the contract of th		eoupat ys selipeopl	m i raiti 16 tust b	
Signature: D	Date:			1340 30

Website: www.swpedscare.com



1020 S. 8th Street • Deming, NM 88030 Ph. (575)936-4350 • Fax (575)-936-4351 Afterhours/Emergency Number: (575) 545-3985

Release of Medical Records

Patient Name	Hoto Consent F	Dat	e of Birth
Mailing Address		Pho	one #
City	Z	ip Code	dent Name:
	(tast)	(First)	
	thwest Pediatric & Fai 1020 S. 8 th St Deming, NM 88 575-936-4350 Fax 5	dian, consent 00 0	l, patient/guar
	To Obtain Informatio	n FROM:	
Name:			
Mailing Address:	e (please check	e images may bi	I agree that the
City, State, Zip Code:	d for identity protec	d in the health reco	•place
Phone:	fax:	ronically e-mailed to	
 ONLY Last Visit's Progress Problem List Medication List Radiology Reports Lab Reports 	nals for educati ato N		s (post-operative)
ease Send records to our secure e	email at: III	slow. Leading that	By cianing ha
	mail.com@direct.M		
owpeased eg.	or		
Fax t	the records to (575) 9	36-4351.	
	The state of the s		
understand that I may request to cand by time, and that information about n by yone but the above mentioned. I also be held liable for any misuse of informa	ny child or anything pe o understand that Sou	rtaining to me will no thwest Pediatric & Fa	t be released to
		/	/
gnature of patient/guardian	Print	D	ate
Website: www.swpe	dscare.com Emc	ail: info@swpedscare.	com



1020 S. 8th Street • Deming, NM 88030 Ph. (575)936-4350 • Fax (575)-936-4351 Afterhours/Emergency Number: (575) 545-3985

CANCELATION NO SHOW POLICY

We at Southwest Pediatric & Family Care, LLC understand that situations arise in which you must cancel your appointment(s). However, if you will kindly extend the office courtesy and give us a call before the 24-hours of cancelation; this will enable another patient to be scheduled within that time slot.

Due to many cancellations with NO notice, appointments which are not cancelled with no notice or cancelled less than 24-hours of the appointment will be subject to a **\$50.00** cancellation fee.

This No Show fee is a patient responsibility (Medicaid, Medicare, and Commercial Insurances)

En Southwest Pediatric & Family Care, LLC entendemos que surgen situaciones en las que debe cancelar su(s) cita(s). Sin embargo, si extiende la cortesía de llamar antes de las 24 horas de cancelación; esto permitirá programar a otro paciente dentro de su mismo tiempo.

Debido a muchas cancelaciones sin previo aviso, las citas que no se cancelen sin previo aviso o se cancelen a menos de 24 horas de la cita estarán sujetas a una tarifa de cancelación de **\$50.00**.

Esta tarifa de No Show es una responsabilidad del paciente (Medicaid, Medicare y Seguros Comerciales)

Signature		Date	

Website: www.swpedscare.com



1020 S 8th St, Deming, NM 88030

(575)936-4350 (main) (575)936-4351 (fax)

HIPAA Consent Form

I Understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information can be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare provider who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have been informed by you of your Notice of Privacy practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this Consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and may contact this organization at any time at the address listed above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Name of Patient:	
Date of Birth:	
Guardian (print):	
Address:	
Signature:	Date: