# Southwest Pediatric & Family Care, LLC

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

**Patient Information**

| | | | |
|---|---|---|---|
| First Name: | Last Name: | Middle Name Initial: | Date of birth: |
| Address: | | | Mobile number: ( ) - |
| City: | State: | Zip code: | Home Number: ( ) - |
| Other names used: | | Email address: | |
| Gender: M ☐ F ☐ | Social Security Number: | Preferred language: | Driver's License #: |
| Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separate ☐ Widower ☐ Life partner | Preferred contact: ☐ Mail ☐ Email ☐ Phone | Ethnicity: ☐ Refuse to answer ☐ Hispanic/Latino ☐ Non-Hispanic | Race: ☐ American Indian or Alaskan ☐ Native ☐ Asian ☐ Native Hawaiian/other pacific ☐ White ☐ Other |
| Occupation: | Employer Name: | Employer Address: | Employer Phone: ( ) - |

**Person Responsible (Guarantor)**

| | | | |
|---|---|---|---|
| First Name: | Last Name: | Middle name initial: | Date of birth: |
| Address: | | | Mobile number: ( ) - |
| City: | State: | Zip code: | Home Number: ( ) - |
| Social Security Number: | Preferred language: | Driver's License #: | Relationship to the patient: |

**Emergency Contact**

| | | | |
|---|---|---|---|
| First Name: | Last Name: | Middle name initial: | Date of birth: |
| Address: | | | Mobile number: ( ) - |
| City: | State: | Zip code: | Relationship to the Patient: |

**Primary Insurance**

| | | | |
|---|---|---|---|
| Insurance company: | Name of policyholder: | Date of birth: | Relationship to the Patient: |
| Policy Number: | | Group number: | |

**Secondary Insurance**

| | | | |
|---|---|---|---|
| Insurance company: | Name of policyholder: | Date of birth: | Relationship to the Patient: |
| Policy Number: | | Group number: | |

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## NEW PATIENT HISTORY

**Reason for the visit:** ☐ No health problems ☐ Establish with new provider

| | |
|---|---|
| 1. | 2. |
| 3. | 4. |

**Pharmacy Information**

| *Primary Pharmacy:* | *Secondary Pharmacy:* |
|---|---|
| Name: | Name: |
| Address: | Address: |

**Advanced Directives**

☐ None ☐ Do Not resurrect ☐ Power of Attorney ☐ Testament ☐ Proxy to make decisions

**Drug List- Lists all medications you take, prescription and over-the-counter.**

☐ ***I do not take medication***

| *Name of the drug* | *How many times a day* | *Dosage* |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

**Drug and Food Allergies-Lists all known allergies (medication, food, animals, etc.)**

☐ ***No known allergies***

| | |
|---|---|
| 1. | 3. |
| 2. | 4. |
| 5. | 6. |

**Medical History- Check mark if you have ever experienced the following conditions and the year**

| *Condition* | *Year* | *Condition* | *Year* |
|---|---|---|---|
| ☐ None | | ☐ High blood pressure | |
| ☐ Acid reflux | | ☐ High cholesterol | |
| ☐ Anemia | | ☐ Irritable bowel syndrome | |
| ☐ Angina | | ☐ Arrhythmia/palpitations | |
| ☐ Anorexia/bulimia | | ☐ Joint problems | |
| ☐ Anxiety/panic attacks | | ☐ Kidney problems | |
| ☐ Arthritis | | ☐ Liver problems | |
| ☐ Asthma | | ☐ Migranas/headaches | |
| ☐ Atrial fibrillation | | ☐ Mobility problems | |
| ☐ Bleeding/clotting | | ☐ Osteoporosis | |
| ☐ Bronchitis | | ☐ Pneumonia | |
| ☐ Cancer- (Type:_____) | | ☐ Psychiatric problems | |
| ☐ Dependence on drugs/alcohol | | ☐ Prostate problems | |
| ☐ COPD/emphysema | | ☐ Enviromental allergies | |
| ☐ Crohn's disease | | ☐ Sexually transmitted disease | |

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| | | | |
|---|---|---|---|
| ☐ Dementia/Alzheimer's | | ☐ Dermatology condition | |
| ☐ Depression | | ☐ Stroke | |
| ☐ Diabetes | | ☐ Seizures/epilepsy | |
| ☐ Gout | | ☐ Thyroid disease | |
| ☐ Cholecystitis | | ☐ Tonsillitis | |
| ☐ Gynecology problems | | ☐ Tuberculosis | |
| ☐ Heart disease/heart attack | | ☐ Ulcers | |
| ☐ Hepatitis | | ☐ Urinary problems | |
| ☐ Other:_____ | | ☐ Other:_____ | |

**Surgical history- Mark or list all surgical procedures and year**

| *Surgical procedure* | *Year* | *Surgical procedure* | *Year* |
|---|---|---|---|
| ☐ **None** | | | |
| ***Only Male*** | | | |
| ☐ Prostate surgery | | ☐ Vasectomy | |
| ***Only Female*** | | | |
| ☐ Augmentation mammoplasty | | ☐ Mastectomy | |
| ☐ Tubal ligation | | ☐ Myomectomymia | |
| ☐ Breast biopsy | | ☐ Reduction mammoplasty | |
| ☐ Caesarean section | | ☐ Abdominal hysterectomy | |
| ☐ Dilation and curettage | | ☐ Vaginal Hysterectomy | |
| ☐ Hysterectomy | | | |
| ***Other:*** | | | |
| 1. | | 2. | |
| 3. | | 4. | |
| 5. | | 6. | |
| 7. | | 8. | |
| 9. | | 10. | |

**Previous hospitalizations**

| *Year* | *Reason* | *Hospital name* | *Year* | *Reason* | *Hospital name* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Health Maintenance- Check if you've received the following tests and the date**

| *Test* | *Date* | *Test* | *Date* |
|---|---|---|---|
| ☐ None | | ☐ Gynecological exam | |
| ☐ Breast exam | | ☐ Influenza vaccine | |
| ☐ Cardiac stress test | | ☐ Lipid panel | |
| ☐ Colonoscopy | | ☐ Mammogram | |
| ☐ Bone Density (DEXA scan) | | ☐ Pap test | |
| ☐ Echocardiogram | | ☐ Physical exam | |
| ☐ Electrocardiogram | | ☐ Pneumococcal vaccine | |
| ☐ Eye exam | | ☐ Spirometry | |
| ☐ Blood hidden in stool | | ☐ Sigmoidoscopy | |
| ☐ Foot exam | | ☐ Tetnus vaccine | |

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| **Social/personal background** | | | |
|---|---|---|---|
| Do you have children? ☐ Yes ☐ No | How many? | Female: | Male: |

***Tobacco Use***

| | | |
|---|---|---|
| ☐ None<br>☐ Previously/ Year You Stopped Smoking: _____ | ☐ Daily ☐ Weekly ☐ Less<br># of Cigars/day:_____ | ☐ Chew ☐ Pipe<br>☐ Cigar ☐ Cigarette<br>☐ Other: |

***Alcohol Use***

| | | |
|---|---|---|
| ☐ None<br>☐ Previously/ Year You Quit Drinking:_____ | ☐ Daily ☐ Weekly ☐ Less<br># of Drinks/weekly:_____ | ☐ Beer ☐ Wine<br>☐ Liquor ☐ Other: |

***Recreational Drugs***

☐ None ☐ History of injectable drugs ☐ Previous/current use
Specify:

***Exercise***

☐ Moderate ☐ Vigorous ☐ Sedentary # Days / week :

***Sleep Pattern***

☐ Changes ☐ No Changes
Specify:

***Caffeine*** Consumption

☐ None ☐ Daily ☐ Weekly ☐ Less
# of drinks/weekl:_____

Have you had a fall in the last year? ☐ Yes ☐ No

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## Medical Photo Consent Form

Patient Name: _____ DOB:_____/_____/_____
(First) (Last)

I, patient/guardian, consent of medical images and/or video being made.

**I agree that the images may be... (please check below to show consent)**

| | Yes | No |
|---|---|---|
| • ...placed in the health record for identity protection | _____ | _____ |
| • ... electronically e-mailed to any treating health professional | _____ | _____ |
| • ... used by health professionals for education and training purposes | _____ | _____ |

**By signing below, I confirm that I understand this consent form**

**Name of Patient/Guardian :** _____
(Print)

**Signature:**_____ **Date:**____/____/_____

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## Release of Medical Records

| Patient Name | Date of Birth |
|---|---|
| Mailing Address | Phone # |
| City State Zip Code | |

**I Authorize:**

***Southwest Pediatric & Family Care, LLC***
***1020 S. 8th St***
***Deming, NM 88030***
***Ph. 575-936-4350 Fax 575-936-4351***

To Obtain Information FROM:

Name:_____

Mailing Address:_____

City, State, Zip Code:_____

Phone:_____ fax:_____

**I Authorize** the release of the following health information:

- ☐ **ONLY** Last Visit's Progress Note
- ☐ Problem List
- ☐ Medication List
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Consult Notes
- ☐ Surgical Reports (post-operative)
- ☐ Hospital Discharge Summaries
- ☐ Entire Record

**Please Send** records to our secure email at:

**swpedscaregmail.com@direct.MediTouchEHR.com**
or
Fax the records to **(575) 936-4351.**

I understand that I may request to cancel this release of information in writing for whatever reason, at any time, and that information about my child or anything pertaining to me will not be released to anyone but the above mentioned. I also understand that Southwest Pediatric & Family Care LLC cannot be held liable for any misuse of information from the above mentioned person.

_____ _____ ___/___/___
Signature of patient/guardian Print Date

Southwest Pediatric & Family Care, LLC
Lovingly caring for babies, kids, teens & adults

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## 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)***

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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

Southwest Pediatric & Family Care, LLC

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: _____