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

Southwest Pediatric & Family Care, LLC
1020 S 8th st Deming, NM 88030
Phone (575) 936-4350 Fax (575) 936-4351

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 ☐ Separated ☐ 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:	

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 ☐ Previously/Year You Stopped Smoking:	☐ Daily ☐ Weekly ☐ Less # of Cigars/day:_____	☐ Chew ☐ Cigar ☐ Other:	☐ Pipe ☐ Cigarette	
Alcohol Use				
☐ None ☐ Previously/Year You Quit Drinking:	☐ Daily ☐ Weekly ☐ Less # of Drinks/weekly:_____	☐ Beer ☐ Liquor	☐ Wine ☐ Other:	
Recreational Drugs				
☐ None ☐ History of injectable drugs	☐ Previous/current use Specify:			
Exercise				
☐ Moderate ☐ Vigorous	☐ Sedentary	# Days/week:		
Sleep Pattern				
☐ Changes Specify:	☐ No Changes			
Cafeine Consumption				
☐ None ☐ Daily ☐ Weekly ☐ Less # of drinks/weekl:_____				
Have you had a fall in the last year? ☐ Yes ☐ No				

Family Demographics				
Sus otros hijos están siendo tratados aquí? ☐ Yes ☐ No	If so, How many?	Female:	Male:	
If so, Please fill out information below				
Name: DOB:	Name: DOB:	Name: DOB:		
Name: DOB:	Name: DOB:	Name: DOB:		
Name: DOB:	Name: DOB:	Name: DOB:		
Name: DOB:	Name: DOB:	Name: DOB:		

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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

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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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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 or Commercial Patients)

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 responsabilidad del paciente (Medicaid o pacientes comerciales)

_____ _____

Signature Date

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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: _____