Mariposa Family Medicine

New Patient Registration and Consents

Name:_____

DOB:_____ Last 4 digits of SS #:_____

Address:_____

City:_____NM Zip:_____

Primary Phone:_____Work Phone:_____

Email:_____Occupation: _____

Marital Status: Single _____ Married_____ Divorced _____ Widow(er) _____

Living with Partner _____ Spouse or Partner's Name_____

Emergency Contact

Name:_____Relationship:_____

Phone:_____

Previous/Other Providers: _____

Insurance Information

Primary Insurance: _____ Member ID#_____Group #_____

Secondary Insurance:_____Member ID#_____Group #_____

Are you the primary insured? Yes ___No ___

If no, please provide the following information:

Primary insured's name: _____Date of birth: _____

Relation to patient: _____

Local Pharmacy: _____ Mail Order: _____

How did you hear about us? _____

If referred by another provider or patient, whom? _____

Mariposa Family Medicine

Consent for Medical Treatment

I hereby authorize employees and agents of Mariposa Family Medicine (Nurse Practitioners, employees, and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency as determined by the Medical Director/FNP Tani Schare.

Patient Signature: _____Date: _____

Authorization to Share Health Information

I authorize the names listed below to have access to my medical information. These people may call and speak with the provider and or staff about me regarding **appointments,** referrals, medications, diagnosis, and diagnostic studies. I **have the right to** revoke this agreement in part or whole at any time with notification in writing. If you do not wish anyone to have access, leave it blank.

Authorized Name	Relationship to Patient
_____	_____
_____	_____

Billing Statement Delivery Options

Billing statements will be sent to patients by the following options. **Mark the box for the method you are selecting. Only one form needed per household.**

☐ Email

☐ Text Message

For selective patients, a mailed statement can be provided. These must be approved by the owner in writing. If you want to change your billing selection you can fill out a change of billing form.

Name: _____Signature: _____Date: _____

Mariposa Family Medicine

Insurance and Patient Payment Policies

Proof of insurance- We must verify your identification and proof of insurance at each visit. If you fail to provide us with the correct insurance information at check-in and your insurance is not active or valid, you will be responsible for the claim if insurance does not cover.

1. **Co-payments-** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company and is a portion of our payment. Copays are also due on the date of telemedicine visits. Patients will find a link to pay on the telemedicine confirmation email.

2. **Claims submission -** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim.

3. **Coverage changes-** If your insurance changes, **you must notify us at least 72 hours prior to your next visit** so we can make the appropriate changes to help you receive your maximum benefits. **We cannot verify insurance on the day of your visit so your appointment will be rescheduled.**

4. **Non-payment- If** your account is over 90 days past due from the date of the statement, you will receive a letter stating that you have 30 days to pay your account in full. **Partial payments will not be accepted unless patients are enrolled in our payment plan.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and all costs associated with recovery will be your responsibility.

Late Cancellations- Your appointment is confirmed when you schedule it, but we do provide multiple a appointment reminders prior to your appointment as a courtesy. While late cancellations (less than 24 hours before your appointment) are not charged a fee, if at any time you have more than 2 late cancellations, you will be charged a Late Cancellation Fee of $40.00 and may be discharged if another occurs going forward. Patients can cancel appointments on text confirmation and may call the office and leave a message more than 24 hours prior to the scheduled time.

Missed Appointments- Patients are given multiple ways to cancel an appointment, and there are other patients that can use that time. Missed appointments will incur a fee.

FIRST Time - If you do not show to an appointment for the first time, you will be charged a $40.00 fee.

SECOND Time - If you do not show a second time, you will be charged a $50.00 fee.

THIRD Time - If you do not show a third time, you will be charged a $75.00 fee.

Patients who miss 3 appointments are subject to dismissal from the practice.

The late cancellation and missed appointment fees are the responsibility of the patient and not the insurance company and are due at the time of rescheduling. We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office as soon as possible.

I have read and understand the above Practice Policy information and agree to the terms as stated above:

Patient Name: _____ Signature: _____Date: _____

Mariposa Family Medicine

Practice Policies

Patients need to arrive within 10 minutes of their appointment time. If it is more than 10 minutes, patients will have to reschedule and is considered a late cancellation. New patients need to arrive 15 minutes prior to their first appointment time and have all the intake forms and medical history forms completed at check-in. If you need to fill out these forms, you must arrive at least 25 minutes prior to your appointment time to fill out the forms. If not done, you may need to reschedule your appointment, or the provider will spend only the remainder of the appointment time with you and an additional appointment will be scheduled.

Follow-up appointments must be scheduled for refills on controlled substances and weight loss medications at minimum of every 12 weeks.

Providers will not prescribe any new medication without a visit. This includes ANY antibiotics, antivirals, eye drops, topicals, oral medications for any reason. Same day/next appointments are available daily but can fill up so plan accordingly.

Patients need to contact their pharmacy for any refills of a non-controlled medication. The pharmacy will send refill requests to the provider electronically or by fax. Please do not call the office unless a refill was denied and you need to schedule an appointment or if the prescription is a controlled substance (medications for pain, sleep, weight loss, ADD, testosterone replacement)

Any phone messages for the provider may take up to 3 business days to be returned by the staff. Providers do not routinely take phone calls.

Portal messages are not always answered quickly. Messages in the portal will be reviewed within 7 -10 days by staff and/or providers. If you have more urgent needs or concerns, please call the office. The portal is not to be used for new issues or concerns. Those will require an appointment to assess and address. The portal is not for scheduling an appointment. Please call the office for those. Pt messages must go through the portal. No patient messages sent to any business email will be answered as this is not HIPAA secure. No medical records will be sent in any email and can be sent in the portal, picked up in the office or mailed.

Any requests for provider letters and/or forms for the provider to fill out may take up to 7-10 business days to complete. A copy will be sent to the patient in the portal and the original may be picked up at the front desk.

All patients who have medication(s) prescribed by MFM must have an annual wellness visit in order to receive refills. All other patients must be seen every 3 years to stay in the practice.

Annual labs may be ordered prior to your annual appointment as deemed necessary by the provider. If you do not get a portal message notifying you that orders were placed, do not go to the lab. Providers may want to review any additional lab needs at your annual and will order labs during or after your visit.

I have read and understand the above Practice Policies and agree to the terms as stated above:

Patient Name: _____ Signature: _____Date: _____

Mariposa Family Medicine

Adult Health History

Name _____ Date of birth

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all five pages. If you cannot remember specific details, please provide your best guess.

Main reason for today's visit:_____
Other concerns: _____

Where were you getting your care before?_____
Pharmacy: Local_____ Mailorder_____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? Feeling down, depressed or hopeless? ☐ **No** ☐ **Yes**

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you.

General
___ Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills
___ No problems

Skin
___ New or change in mole
___ Rash / itching
___ No problems

Breast
___ Breast lump / pain / nipple discharge
___ No problems

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss / ringing in ears
___ No problems

Eyes
___ Change in vision / eye pain / redness
___ No problems

Cardiovascular
___ Chest pain / discomfort
___ Palpitations (fast or irregular heartbeat)
___ No problems

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Short of breath with exertion
___ No problems

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation
___ No problems

Genitourinary
___ Leaking urine
Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
Concern with sexual function
___ No problems

Musculoskeletal
___ Neck pain
___ Back pain
___ Muscle / joint pain _____
___ No problems

Endocrine
___ Heat or cold sensitivity
___ No problems

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising
___ No problems

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls
___ No problems

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections
___ No problems

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration
___ No problems

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ No problems

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____ Pneumovax (pneumonia) _____

COVID _____ Influenza (flu)_____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

MEDICATIONS: Please list all **prescriptions and non-prescription medications, vitamins, supplements, herbs, inhalers**, etc.
Use the back of this form for additional space

Medication Dose (e.g. mg/pill)

_____

_____

_____

Allergies or intolerance to medications, foods (include type of reaction): _____

_____ ☐ NONE

HEALTH MAINTENANCE SCREENING TESTS:

Lipid	Date _____	Abnormal?	☐ No	☐ Yes
Colonoscopy	Date _____	Polyp?	☐ No	☐ Yes
(MEN) PSA	Date _____	Abnormal?	☐ No	☐ Yes
(WOMEN) Mammogram	Date _____	Abnormal?	☐ No	☐ Yes
Pap Smear	Date _____	Abnormal?	☐ No	☐ Yes
Bone Density Test				

PERSONAL MEDICAL HISTORY: Do you have now or have you had any of the following conditions? If no, LEAVE blank

Condition	Yes= Y	*Current*	*Past*	*Comments*
Alcohol / Drug abuse				
Allergy (Hay Fever)				
Anemia				
Anxiety				
Arthritis (Rheumatoid)				
Arthritis (Osteoarthritis)				
Asthma				
Bladder / Kidney Problems				
Blood Clot (leg)				
Blood Clot (lung)				
Blood Transfusion				
Breast Lump (benign)				
Cancer Breast				
Cancer Colon				
Cancer Other Type				
Cancer Ovarian				
Cancer Prostate				
Cataracts				
Chicken Pox				
Colon Polyp				
Coronary Artery Disease				
Depression				
Diabetes (adult onset)				
Diabetes (childhood onset)				
Diverticulosis				
Emphysema				
Fractures (broken bones)				Where?
Gallbladder Disease				
Gastroesophageal Reflux (Heartburn/GERD)				
Glaucoma				

PERSONAL MEDICAL HISTORY Continued: *Condition*		*Current*	*Past*	*Comments*
Gout				
Gynecological Conditions (Endometriosis)				
Gynecological Conditions (Fibroids)				
Gynecological Conditions (Other)				
Heart Attack				
Hepatitis – Type A				
Hepatitis – Type B				
Hepatitis – Type C				
Hepatitis – Other				
High Blood Pressure				
High Cholesterol				
Hip Fracture				
Irritable Bowel Syndrome				
Kidney Disease / Failure				
Kidney Stones				
Liver Disease				
Migraine Headaches				
Osteoporosis				
Pneumonia				
Prostate (enlargement)				
Prostate (nodules)				
Seizure / Epilepsy				
Skin Condition (Eczema)				
Skin Condition (Psoriasis)				
Skin Condition (Abnormal Moles)				
Sleep Apnea				
Stomach Ulcer				
Stroke				
Thyroid (Nodule)				
Thyroid High (Overactive) / Hyperthyroidism				
Thyroid Low (Underactive) / Hypothyroidism				
Other (list)				
Other (list)				

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal finding or complications. ☐ **NONE**

Surgical Procedure		*Yes*	*Year*	*Comments*
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY Continued: *Surgical Procedure*		*Yes*	*Year*	*Comments*
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section

FAMILY HISTORY – Indicate which relative has had the following diseases (

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Child	Comments
No significant history known										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

Tobacco Use ?
Cigarettes Vape Chew Cigar

_____ Current smoker: Packs/day: _____ # of years:

Quit date: _____ How many years did you smoke? _____

Approximatety how many packs a day did you smoke?

Do you drink alcohol? ☐ No ☐ Yes
# of drinks/week: _____ Beer Wine Liquor

Drug Use
Do you use marijuana or recreational drugs? ☐ No ☐ Yes

Have you ever used needles to inject drugs? ☐ No ☐ Yes

Exercise: Do you exercise regularly? ☐ Yes ☐ No
What kind of exercise? _____

_____

How long (minutes)? _____ How often? _____

Diet: How would you rate your diet? ☐ Good ☐ Fair ☐ Poor
Would you like advice on your diet? ☐ No ☐ Yes

Have you completed an Advance Directive for Health Care, Living Will, or MOST Form? ☐ Yes ☐ No
POA-
Name_____

Sexual partner(s) is/are/have been: male female
Birth control method (circle below all that apply): ☐ None needed
Condom, pill, IUD, vasectomy, other _____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

SOCIAL HISTORY:

Occupation (or prior occupation): _____ retired/unemployed/leave of absence/disabled (circle one)

Employer: Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____ Number of children: _____ Ages if under 18 years: _____

Thank you for taking the time to fill this out.