Mariposa Family Medicine

New Patient Registration Form

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Cell Phone #	Other Phone #	E-mail	
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Driver's License #
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name (If Applicable)		
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the practice and/or the provider you are seeing today?

☐ Family Member _____ ☐ Established Patient _____

☐ Hospital _____ ☐ ER _____ ☐ Insurance Listing

☐ Physician Referral _____ ☐ Web Search ☐ Location/Drive By

Complete this section only if the patient is a minor

Responsible Party

Responsible Party Last Name	First Name	Middle Name	
Address (Street or Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
☐ Male ☐ Female	Date of Birth	Age	Driver's License #

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City	State Zip	City	State Zip
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City	State Zip	City	State Zip

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Revised 1/19

Consent to Treat & Financial Responsibility

Mariposa Family Medicine

Consent to Treat

I hereby authorize employees and agents of Mariposa Family Medicine (including physicians, physician assistants and nurse practitioners and other 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.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Parent or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to Mariposa Family Medicine (hereinafter "MFM" and/or the attending provider for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Mariposa Family Medicine. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of MFM, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Revised 1/19

Mariposa Family Medicine

Health Information Sharing & Emergency Contact(s)

I authorize Mariposa Family Medicine Staff to share my medical information with the following individual(s)

Name (please print)	Phone

In an emergency I authorize Mariposa Family Medicine to contact:

Name (please print)	Phone

Signature of Patient, Parent, or Legal Guardian **Date**

Mariposa Family Medicine

Mariposa Family Medicine Payment and Appointment Policies

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your current coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. 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 in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably 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 or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Non-payment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged

from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our provider will only be able to treat you on an emergency basis for cash.

8. Missed appointments. Your appointment is considered to be confirmed when you schedule it, but we do provide multiple appointment reminders prior to your appointment as a courtesy. All appointment cancellations must be received the previous business day, during clinic hours. Cancellation messages left by voicemail the night before your appointment are considered a "Late Cancellation." Monday appointments must be cancelled by the previous Friday, before 1pm (closing time). Late Cancellations and "No Shows" will result in a $40 charge that is due in full at time of check in for your subsequent appointment. New patients are usually discharged from our practice if they have an appointment Late Cancel or No Show for any of their first 3 appointments. For all patients, a second appointment "No Show" will result in discharge from our practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

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

_____

Printed Name

_____ _____

Signature of patient or responsible party Date

Mariposa Family Medicine

Phone: (505) 859-4191

Fax: (505) 308-3192

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

City State Zip Code

Authorizes: **Name of Facility/Provider** _____

Address: _____

City, State, Zip Code: _____

Please release the following medical information to:

Mariposa Family Medicine
5910 Cubero Dr NE Ste C
Albuquerque, NM 87109
(505) 308-3192 (FAX)

☐ H&P /Annual ☐ Last 3 Progress Notes ☐ Labs within 2 years ☐ X-Ray Reports
☐ Pathology Reports ☐ Other (please specify)_____

Purpose of Disclosure: Medical Care

I understand that I may revoke this authorization in writing at any time, except to action has been taken in reliance on it and that in any event this authorization shall

☐ **not expire**; or

☐ Shall expire in 180 DAYS from the date of my signature, unless specified in writing here:

To The Party Releasing This Information:

I, the undersigned, have read the above and authorize the person or facility noted above to disclose such information as herein contained. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient any may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

_____

Patient's Signature **Date**

_____

Witness **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. If you are a current patient there is a shorter update form you can use. 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? _____

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. List other concerns above.

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) _____

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

MEDICATIONS: Please list (or show us your own printed record) 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 (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 (current) or have you had (past) any of the following conditions? □ **NONE**

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 and continue to page 5 (Other Health Issues)

FAMILY HISTORY – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	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_____

Sexually involved currently: No □ Yes □
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.