GILA REGIONAL
Family Medicine

A Department of Gila Regional Medical Center

3185 North Leslie Road | Silver City, NM 88061 | (575) 534-0400

M E M O

TO: **Our New Patients**

FROM: **The Team at Gila Family Medicine**

RE: **New Patient Packet**

Dear Valued Patient:

Thank you for choosing Gila Family Medicine as your healthcare partner. We look forward to seeing you at your upcoming ***New Patient*** visit. Please complete the enclosed ***New Patient Packet*** and bring with you to your visit, along with the following information:

- Picture ID e.g. drivers' license
- Your current medical insurance card(s)
- A list of your current medications OR your medication bottles

PLEASE ARRIVE **15 MINUTES** BEFORE YOUR APPOINTMENT SO THAT OUR STAFF CAN PROCESS YOUR NEW INFORMATION. Our goal is for you to be in the hands of our clinical team at your appointment time.

If you have any questions, please call us at 575-534-0400.

Date: ___________________________

Last Name______________________________ **First Name**___________________________ **DOB**_________________

Please answer every question on the following pages.

[Type here]

Health History Questionnaire

Please check any of the following medical problems that you have had.

__Abnormal Weight Loss
__Abnormal Weight Gain
__Excessive Fatigue
__Insomnia
__Anemia
__Cancer or Tumor
__Breathing Problems
__Glasses/Contacts
__Glaucoma
__Cataracts
__Other vision problems

__Hearing Loss
__Ear Problems
__Ringing in Ears
__Allergies
__Frequent Sinus infections

__Dentures
__Dental Problems
__Recurrent sores in mouth
__Angina
__Chest Pain
__Irregular Heartbeat
__Heart Murmur

__Rheumatic Fever
__High Cholesterol
__Heart Failure
__Heart Attack
__High Blood Pressure

__Frequent Bronchitis
__Emphysema
__Pneumonia
__Asthma

__Heartburn
__Ulcers
__Gallbladder disease
__Blood in Stool
__Diarrhea
__Constipation
__Hemorrhoids
__Abdominal Pain
__Colon Polyp

__Urinary Frequency
__Bladder Infections
__Prostate problems
__Kidney problems/incontinence

__Arthritis or Joint Pain
__Gout
__Broken Bones

__Rashes
__Hives
__Moles

__Seizure
__TIA
__Stroke
__Numbness
__Weakness
__Memory Loss
__Headaches

__Depression
__Anxiety/Panic Attacks
__Suicide Attempt
__Physical Abuse
__Sexual Abuse
__Mental Illness
__Diabetes
__Thyroid Disease

__Abnormal Mammogram
__Breast Lump
__Abnormal Pap smear
__#Pregnancies
__Live Births
__Miscarriages
__Abortions

__HIV/AIDS
__Hepatitis
__Tuberculosis
__Sexually transmitted disease

Other Medical Problems:

1________________________
2________________________
3________________________
4________________________
5________________________

List <u>all surgeries</u> you have had:

1________________________
2________________________
3________________________
4________________________
5________________________

List all *<u>medication allergies</u>*:

1________________________
2________________________
3________________________
4________________________
5________________________

List all current Medications, Supplements, and Vitamins and doses:

1__________________________ 2 ________________________ 3__________________________
4__________________________ 5 ________________________ 6 __________________________
7__________________________ 8_________________________ 9__________________________

Please list the <u>last year</u> in which you had any of the following:

Physical Exam________ Sigmoidoscopy/Colonoscopy (circle which one) _________ Cholesterol__________
Pap Smear___________ Stool Cards for Colon Cancer_________ Dental Visit__________

Mammogram________ Rectal/Prostate Exam______________ Eye Exam___________
Testicular Exam_______ Bone Density____________________ Tetanus_____________
Pneumonia shot__________ Hepatitis B series__________ Flu shot_____________
PPD (TB test) _________ Measles, Mumps, Rubella (MMR) ____________

Please describe your use of tobacco products.

____None ____Cigarettes ____Smokeless Tobacco ____Pipe ____Cigars
How much do you or did you smoke per day?________ For how many years?________ How soon after waking?________
Do you wish to quit? ____Now ____Soon ____Eventually ____Never
Have you quit? ________ When? __________
How much alcohol do you drink weekly on average? _____________
Have you used illicit drugs? _____Yes _____No If yes, which ones? ___________________
How much caffeine do you drink daily? _____Yes _____No If yes, how much?_________________
Are you sexually active? ___________ Are your partners male, female, or both? (circle)
Do you use contraception? _________ If yes, which method? ____
Have you ever had a blood transfusion? ______Yes ______No If yes, what year? __________

Please check which of the following behaviors you follow:

____Wear seatbelt ____Wear helmet while riding bike or motorcycle ____Smoke detector in house
____Home fire extinguisher ____Perform regular self-breast exam regularly ____Perform self-testicular exam
____Living Will ____Frequent exposure to animals ____Low fat diet
____Exercise > 3x per week ____Carbon Monoxide monitoring ____Gun in house

Please check if there is a history of any of the following disease in your family:

____Heart disease ____Diabetes ____Colon Cancer ____Prostate Cancer
____Osteoporosis ____Breast Cancer ____Ovarian Cancer ____Skin Cancer
____High Cholesterol

Please fill in the following family history.

Age (or age at death) Medical Problems
Father: ________________ ____
Mother: __________________ ____
Siblings: _________________ ____

Patient / Legal Guardian Signature: ____ **Date:** _______________________________

Consent to Receive Medical Treatment

Patient Demographic Form

Please PRINT

Date: ________________________

Last Name_____________________ **First Name**__________________ **M.I.** _____**Nickname**______________

D.O.B: _________________________**Social Security Number**: ____________/____________/_______________

Marital Status: (Circle One) MARRIED / SINGLE / DIVORCED / WIDOWED / LIFE PARTNER

Mailing Address:___________________________**City:** ______________**State**:________**Zip:**____________

Home#:_____________________ **Cell#:** ______________________**Work#:**___________________________

Preferred Method of Contact: (Circle One) H / C / W **Consent to Receive Texts?** Y/N

Race: ____________________ **Ethnicity:** ________________________

Email Address: ________________@_______________**Preferred Pharmacy:**__________________________

INSURANCE INFORMATION

Primary Insurance:____

Insured's Name (Subscriber):____________________________Relationship to Patient:___________________

Insured's D.O.B:__________/_______/______________ Soc.Sec.# :___________________________________

Policy # or ID#:__________________________________Group #: _____________________________________

Secondary Insurance:____

Insured's Name (Subscriber):____________________________Relationship to Patient:___________________

Insured's D.O.B:__________/_______/______________ Soc.Sec.#:____________________________________

Policy # or ID#:__________________________________ Group #:______________________________________

EMERGENCY NUMBERS

Emergency Contact Name: ____________________________________Relationship: ___________________________

Emergency Contact Home#:_______________________________________Cell#:_________________________________

Secondary Contact Name: _____________________________________Relationship:____________________________

Secondary Contact Home#:____Cell#: ______________________________

Patient/Legal Guardian Signature: _______________________________________ **Date:** ______________________________

This consent provides Gila Regional physicians and mid-level providers with your permission to perform reasonable and necessary medical examinations, testing and treatment on the above-named patient. By signing above, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Privacy Notice

This document is to acknowledge my receipt of Gila Regional Medical Center's Privacy Notice. The Privacy Notice describes how medical information about me may be used and/or disclosed by the GRMC Multi-Specialty Clinic Network or Gila Regional Medical Center and how I can get access to this Information. The effective date of the Privacy Notice I received is 04/14/03.

I understand that I have the right to review the notice prior to signing this Acknowledgment. I understand that GRMC Multi-Specialty Clinic Network and Gila Regional Medical Center reserves the right to change its notice and make the revised or changed notice effective for medical information they already have about me, as well as any information GRMC Multi-Specialty Clinic Network or Gila Regional Medical Center may receive in the future. Should any information on the Privacy Notice change, a revised notice will be published and made available. I may request a copy of the Privacy Notice at any time by contacting GRMC Multi-Specialty Clinic Network or Gila Regional Medical Center.

Authorization for the Release of Health Information

Date: ________________________

Do you give permission for us to share your health information with anyone other than yourself? Yes / No

Do you give permission for us to share access to your electronic Patient Portal? Yes / No

Name_________________________________Relationship________________Phone #___________________

Name_________________________________Relationship________________Phone #___________________

Name_________________________________Relationship________________Phone #___________________

____ ________________________

Patient's Signature (or Legally Authorized Representative) **Date & Time**

____ ______________________

Witness Signature (GRFM Staff Signature) **Date & Time**

I agree (whether signed as a patient or as a legally responsible representative) that in consideration of the services to be rendered to The Patient, I hereby obligate myself to pay on the account, as well as obligating The Patient and Gila Regional Medical Center (GRMC)/GRMC Multi-Specialty Network (GMSN) may look to either or both for payment of any and all charges incurred in accordance with the rates and terms of Gila Regional Medical Center (GRMC)/ GRMC Multi-Specialty Network (GMSN).

In the event that the insurer or third-party payers including Medicare, private insurance and other plans, are involved in payment of charges for services rendered, I authorize payment directly to Gila Regional Medical Center (GRMC)/ GRMC Multi-Specialty Network (GMSN).

I understand that I am financially responsible to Gila Regional Medical Center (GRMC)/GRMC Multi-Specialty Network (GMSN) for charges not covered by this authorization. If the indebtedness guaranteed hereby is placed in the hands of a third party for collection after default, the Undersigned agrees to pay all reasonable collection expenses and/or attorney and court fees.

I acknowledge that patients who do not have insurance are expected to pay charges in full at the time services are rendered.

Release of Medical Information
GRMC/ GMSN may disclose all copies of or any part of the Patient's medical record regarding this visit to the referring/personal physician, to health care facilities to which the Patient may be transferred or to any person or entity that is or may be liable for all or part of GRMC/GMSN charges, including but not limited to insurance companies, utilization review committees working on behalf of insurance companies, employer of the patient, the Department of Labor and Industries, Medicare and/or Medicaid.

I authorize disclosure of any medical information necessary to process related claims. I expressly consent to the release of health care information relating to:

1. Alcohol and/or drug abuse treatment, if any;
2. Drug screening results, if any;
3. Psychiatric diagnosis, treatment of summaries, if any;
4. Test results for HIV, STD's, AIDS (Acquired Immunodeficiency Disease) and related conditions.

I hereby release GRMC/GMSN from all legal responsibility or liability that may arise from disclosure of my record as provided by this paragraph. (This authorization is protected by provisions in the Code of Federal Regulations (42 CFR, Part 2, T6 "Human Immunodeficiency Virus Test Act" 24-213-1 et seq. NMSA 1978 as amended)

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire one year after the date of signature.

By signing below, I acknowledge that I have read, understand and agree to abide by the above and that all information given is true and correct.
General Consent for Care and Treatment: By signing below, I am giving my consent and/or permission to GRMC/GMSN to perform reasonable and necessary medical examinations, testing and treatment. I acknowledge that I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care providers, I am encouraged to ask questions. I voluntarily request GRMC/ GMSN physicians and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at GRMC/GMSN.
I authorize GRMC/ GMSN to file insurance claims regarding my care and treatment with insurers. I authorize payment of insurance benefits be made on my behalf to GRMC/ GMSN for any services rendered. I agree to assist in the processing of claims and benefits.

____ ______________________

Patient's Signature (or Legally Authorized Representative) **Date & Time**

____ ______________________

Witness Signature (GRFM Staff Signature) **Date & Time**

Patient Name: _______________________________________ Date of Birth: ________________

I authorize the disclosure of my individually identifiable health information that may include confidential medical information relating to sexually transmitted disease diagnoses, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) which are protected by provisions set forth in New Mexico House Bill 490 chapter 227 "Human Immunodeficiency Virus Test Act" 1989.

GILA REGIONAL
Medical Center
FAMILY MEDICINE

Authorization for the Release of Health Information

It may also include information about behavioral or mental health diagnoses, or alcohol or drug abuse diagnoses as is documented in the general health record, which is protected by provisions in the Code of Federal Regulations (42 CFR, part 2).

The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)

- ☐ ENTIRE MEDICAL RECORD **OR** THE FOLLOWING PORTIONS/ DATES: From Date____________Thru Date_____________
- ☐ IMAGING RESULTS__________________
- ☐ LAB RESULTS______________________
- ☐ Other: _____________________________

If you would like any of the following sensitive information restricted from disclosure, check the applicable box(es) below:

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Sexually Transmitted Diseases treatment
- ☐ HIV/AIDS-related treatment
- ☐ Mental Health treatment *(Other than Psychotherapy Notes)*
- ☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I hereby authorize the release or disclosure of the above-named individual's health information to the following:

RECEIVE FROM **SEND TO (circle one):**

Facility or Provider Name: ____

Address: ____

____

Phone Number: __________________________________ Fax#_______________________________________

Please Fax requested records to 575-534-0600
Mailing Address:
Gila Family Medicine
3185 N Leslie Rd
Silver City, New Mexico 88061

1. I understand that I have a right to revoke the authorization listed above at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise

revoked, this authorization will expire on the following date, event, or condition: ______________________ (specify an expiration date, event or conditions, this authorization will expire in sixty (60) days)

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
3. I understand that I must provide the facility with at least two (2) working days advanced notice for copies of records that I would like to pick up at the facility.
4. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.
5. I understand that I must provide the facility with at least twenty-four (24) hour notice before coming to the facility to review records. I understand that I am not allowed to review the records by myself but must have a qualified healthcare employee with me during the review.
6. I understand that if I wish to have copies of records made, then the facility will assess a fee for copying the records.
7. I understand that if the copies are of records from another healthcare provider/facility, Gila Multi-Specialty Network is not responsible for the accuracy/completeness of the information of the other healthcare provider/facility that is copied.
8. Gila Multi-Specialty Network will notify me regarding the total amount due for copying and shipping of requested records. I agree that the Facility will only send me the requested information once payment in full has been received.
9. I agree to waive all claims against the facility for release of the requested information.

____ ____________________________

Patient's Signature (or Legally Authorized Representative) **Date & Time**

____ ____________________________

Witness Signature (GRFM Staff Signature) **Date & Time**

Note: If Legal Representative signs, a copy of the Durable Power of Attorney or other legal document granting the right to act in behalf of the Patient must be attached to this authorization. If the patient is deceased, a copy of the legal document stating Legal Representative is the executor or administrator of the patient's estate must be attached to this authorization.