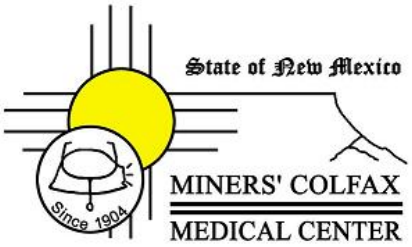


NEW PATIENT REQUEST

Patient Name: _____ DOB: _____ Age: _____

Primary Phone No: _____ Alternate phone no (required): _____

Requested Provider: _____

Referring Provider or previous PCP: _____

Needs/Concerns: _____

_____

FOR PROVIDER USE ONLY:

___ YES. Please request medical records and schedule patient below.

___ PENDING/FOR REVIEW. Please request medical records first.

___ NO. Please inform patient to stay with current provider.

If YES, please schedule patient:

____ At next available open slot for new patients.

____ In ____ days/weeks/months (please encircle)

____ After medical records are received. Nursing staff should inform provider once records are here.

Notes: _____

_____

Provider Signature: _____ Date: _____

FOR REGISTRATION USE:

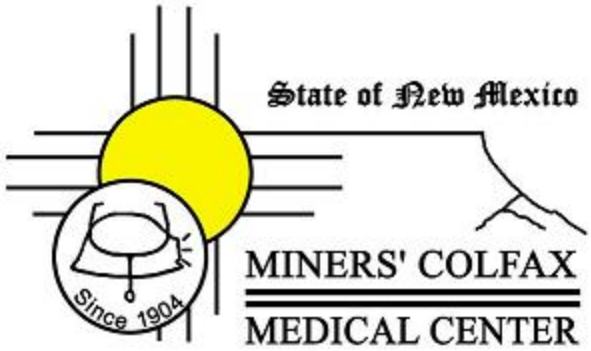
Patient contacted on _____ and appointment scheduled on _____.

Others: Refused scheduling Patient will call back to schedule

Notes: _____

_____

Registration Signature: _____ Date: _____



Initial Evaluation Questionnaire for New Patients

Name: _____ Date: _____
Date of Birth:_____

Allergies (Medications or Food):

_____

_____

Past Medical History (from birth to present):

[ ] High blood pressure
[ ] Diabetes:
On insulin? Y N
[ ] High cholesterol
[ ] Heart attack / MI
[ ] Congestive Heart Failure
[ ] Atrial Fibrillation/Flutter
[ ] Stroke / TIA
[ ] Cancer: _____
[ ] Asthma
[ ] COPD / Emphysema:
On oxygen? Y N
[ ] Gastric reflux (GERD)
[ ] Stomach ulcer
[ ] GI bleeding
[ ] Hypothyroidism
[ ] Anxiety/Depression
[ ] Bipolar disorder
[ ] Kidney stones
[ ] Kidney failure:
On dialysis? Y N
[ ] Gout
[ ] Arthritis
[ ] Spinal stenosis
[ ] Fracture: _____
[ ] Skin problems _____
_____
[ ] Other: _____

_____-

_____

Past Surgical History (from birth to present):

[ ] Heart bypass surgery / CABG
[ ] Heart stent placement
[ ] Heart valve repair/replacement
[ ] Pacemaker / defibrillator
[ ] Appendectomy
[ ] Gall bladder surgery
[ ] Stomach/Bowel surgery
[ ] Kidney stone surgery
[ ] Prostate surgery / TURP
[ ] Hysterectomy
[ ] C-section
[ ] Spine procedure/surgery
[ ] Hip/knee/shoulder replacement
[ ] Arthroscopy/repair (knee/shoulder)
[ ] Cataract or other eye surgery
[ ] Ear tube placement
[ ] Tonsillectomy
[ ] Biopsy: _____
[ ] Other: _____

Family Medical History (diseases diagnosed in family members):

[ ] Father: _____

[ ] Mother: _____

[ ] Brothers/sisters: _____

[ ] Others: _____

Personal/Social History:

Do you use any tobacco products? _____ Yes, I do. For how many years? _____
(smoke or chew) _____ No, I already quit. When did you stop? _____
_____ No, I never tried.

Do you drink alcoholic beverages? _____ Yes, I do. For how many years? _____
_____ No, I already quit. When did you stop? _____
_____ No, I never tried.

Do you use any recreational drugs? _____ Yes, I do. For how many years? _____
(marijuana, meth, cocaine, heroin) _____ No, I already quit. When did you stop? _____
_____ No, I never tried.

Where do you live? [ ] House/apartment [ ] Nursing home [ ] Assisted living

Occupation/work: _____

Please list all medications you take, including prescriptions, over-the-counter medications, and any herbal supplements.

MEDICATION NAME STRENGTH DOSAGE PRESCRIBING DOCTOR or OTC

_____

_____

_____

_____

_____

_____

_____

Continue on back of page if necessary

Request for Transfer of Medical Records

Name: _____ Date of Birth:_____

I authorize the use or disclosure of the above named individual's health information as described below to MCMC Primary Care Clinic (Please circle): Dr Leonardo Lopez, Dr Christine Lopez, Dr. Laith Salih, Dr. Timothy Brininger, Dr. Loretta Conder, Alison Gagnon FNP-C, Lynne Cappellucci FNP-C, Sara J. Lark FNP-C, or Dr. Douglas Smith.
The following individual or organization is authorized to make the disclosure.
Physician/Practice:_____
Address:_____
Phone:_____ Fax:_____

The type and amount of information to be used or disclosed is as follows:

a. Entire Medical Record _____
b. Medication List _____
c. List of allergies _____
d. Immunization record _____
e. Laboratory results _____ From:_____to_____
f. X-ray/Imaging reports _____ From:_____to_____

4. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information on behavioral mental health service, and treatment for alcohol or drug abuse. _____Initial to give authorization for release

5. This information may be disclosed to and used by the following organization:

Miners' Colfax Medical Center Clinic
203 Hospital Dr.
Raton, NM 87740
Phone: (575) 445-7771, 7774, 7776
Fax (575) 445-7773(Main), 445-7742 (L.Lopez, C. Lopez, Salih, Lark)
445-7743 (Conder, Brininger, Gagnon, Cappellucci, Smith)

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization that I must do so in writing and present my written revocation to the entity which was originally authorized to disclose information. I understand that the revocation will not apply to information that has already been released.

7. I,_____, am requesting the disclosure of my medical records because I intend to transfer my medical records.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Representative Relationship Witness