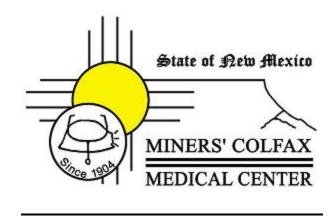


## **NEW PATIENT REQUEST**

Patient Name:	DOB:	Age:	
Primary Phone No:	Alternate phone no (required):		
Requested Provider:			
Referring Provider or previous PCP:			
Needs/Concerns:			
Address:			
FOR PROVIDER USE ONLY:			
YES. Please request medical record	·		
PENDING/FOR REVIEW. Please req	uest medical records first.		
NO. Please inform patient to stay v	vith current provider.		
If YES, please schedule patient:			
At next available open slot for new	patients.		
In days/weeks/months (pleas	se encircle)		
After medical records are received.	Nursing staff should inform provide	er once records are here.	
Notes:			
Provider Signature:		Date:	
FOR REGISTRATION USE:			
Patient contacted on	and appointment scheduled on _		
	Patient will call back to schedu		
Notes:			
Registration Signature:		Date:	



## **Initial Evaluation Questionnaire for New Patients**

Name:	Date:		
Date of Birth:		<del></del>	
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: [] Other:		[] Kidney stones [] Kidney failure:     On dialysis? Y N [] Gout [] Arthritis [] Spinal stenosis [] Fracture: [] Skin problems	
Past Surgical History (from birth	ı to present):		
[] Heart bypass surgery / CABG [] Heart stent placement [] Heart valve repair/replacement [] Pacemaker / defibrillator [] Appendectomy [] Gall bladder surgery [] Other:	[] 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:	

Family Medical History (diseases diagnosed in family memb	pers):
[] Father:	
[] Mother:	
[] Brothers/sisters:	
[] Others:	
Personal/Social History:	
Do you use any tobacco products? Yes, I do. (smoke or chew) No, I already quit. No, I never tried.	For how many years? When did you stop?
Do you drink alcoholic beverages? Yes, I do. No, I already quit. Whe No, I never tried.	For how many years? n did you stop?
Do you use any recreational drugs? Yes, I do. (marijuana, meth, cocaine, heroin) No, I already quit No, I never tried.	
Where do you live? [] House/apartment [] Nursing h	ome [] Assisted living
Occupation/work:	
Please list all medications you take, including prescriptio herbal supplements.	ns, over-the-counter medications, and any
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:			
MCM Vinay The f	IC Prir y Saini ollowi	he use or disclosure of the above mary Care Clinic (Please circle): , Adelanke Chris-Rotimi, CNP ng individual or organization is ractice:	Dr. Laith Sa authorized to	alih,, Sara J. Lar make the disclo	k FNP-C, Dr. Dosure.	
Addr	ess:				<del></del>	
Phone	e:	Fax:				
		d amount of information to be u				
ınc ı	a.	Entire Medical Record	sed of discio	sea is as follows	)•	
	ь. b.	Medication List				
	c.	List of allergies				
	d.	Immunization record				
	e.	Laboratory results		From:	to	
	f.	X-ray/Imaging reports		From:	toto	
	1.	A-ray/imaging reports		110111.	to	
<ol> <li>6.</li> </ol>	I uno	Phon Fax (575)4  derstand that I have the right to a ke this authorization that I must	?' Colfax Me 203 Hos Raton, N e: (575) 445- 45-7742 (Sat 445-7743 (S revoke this a do so in wri	dical Center Clapital Dr. M 87740 -7771, 7774, 772 lih, Lark, Christaini, Smith) uthorization at a	inic  76 Rotimi)  ny time. I unden my written reve	ocation to the
		y which was originally authoriz not apply to information that ha			understand tha	t the revocation
7.	I, beca	use I intend to transfer my medi	, am request cal records.	ing the disclosur	re of my medica	l records
	Signat	ure of Patient or Legal Represer	ntative			Date
	F	Representative Relationship				Witness