



### NEW PATIENT REQUEST

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Primary Phone No: \_\_\_\_\_ Alternate phone no (required): \_\_\_\_\_  
Requested Provider: \_\_\_\_\_  
Referring Provider or previous PCP: \_\_\_\_\_  
Needs/Concerns: \_\_\_\_\_  
Address: \_\_\_\_\_

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#### 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: \_\_\_\_\_

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#### 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):**

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#### **Past Medical History (from birth to present):**

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

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#### **Past Surgical History (from birth to present):**

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

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**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
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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. Laith Salih,, Sara J. Lark FNP-C, Dr. Douglas Smith, Dr. Vinay Saini, Adelanke Chris-Rotimi, CNP

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) 445-7742 (Salih, Lark, Chris-Rotimi)***  
***445-7743 (Saini, 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