Rio Grande
Family Medicine

TELEPHONE (505) 224-7400
FAX (505) 224-7404

PATIENT INFORMATION

PLEASE COMPLETE THIS FORM FULLY AND CLEARLY

Name_____DOB_____Age____
Last First Middle (MM/DD/YYYY)

Social Security #_____-_____-_____ Gender: M___F___ Identifies as: M___F___ Other___

Mailing Adress_____
Street City State Zip Code

Home Phone_____Work# _____Cell#_____

Marital Status: Single___ Married___ Seperated___ Divorced___ Widowed___

Email Address _____

If patient is under the age of 18:
Parent/Guardian name _____ DOB _____ SSN # _____

You have my consent to use my email to sign me up for patient Portal Access: Yes___ No___

You have my consent to use my email to send appointment reminders: Yes___ No___

Employment Status: Full-Time ___ Part-Time___ Self-Employed___ Not Employed___ Retired___

Patients Employer _____ Work Phone # _____

Spouse's Name _____ Spouse's Phone # _____

Is the patient currently in a skilled nursing facility or hospice care?
If yes, name of facility _____
Pharmacy name_____ Phramacy Phone # _____

Emergency Contact Information:
Name _____ Relationship _____ Phone#_____
Name _____ Relationship _____ Phone# _____

Insurance Information:
In order to file insurance claims, we must have complete information below and scanned copies of insurance card(s) and driver's license.
Primary Insurance_____ ID# _____ Group# _____
Insured's Name _____ Insured's DOB _____
Insured's SSN # _____ Relationship to patient _____

Welcome to Rio Grande Family Medicine! We are honored and excited to provide you the highest level medicine and care. Since 1988, our mission has been to treat you with understanding and respect.

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DUE TO HIPAA REGULATIONS, WE MAY ONLY SPEAK TO OTHER HEALTHCARE PROVIDERS REGARDING YOU OR YOUR CONDITION, UNLESS WE ARE GIVEN PERMISSION TO DO SO OTHERWISE. IF YOU WOULD LIKE TO GIVE US PERMISSION TO SPEAK TO OTHER PARTIES, INCLUDING SPOUSE AND OTHER FAMILY, IT IS CRITICAL THAT THEY ARE LISTED BELOW

I understand that I will receive a copy of Rio Grande Family Medicine's Privacy Policy acknowledgment, upon request. I understand that if I have any questions regarding the privacy of my health information or want further explanation of this notice, I can contact Rio Grande Family Medicine.

I authorize the removal of restrictions for the following persons:

Name _____ Home Phone _____

Name _____ Home Phone _____

Name _____ Home Phone _____

Name _____ Home Phone _____

Signature _____ Date _____

Print Name _____

Medical Power Of Attorney

Please note that we cannot honor a medical power of attorney without a copy of the signed and valid legal document. This must be on file before we can discuss patient care.

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Thank you for entrusting us with your care. We are dedicated to a culture of healing and empathy for you and your family. We ask for your help in following our policies so we can provide the best quality care. Please read them carefully, then sign and date to acknowledge your consent below so we may accept you into our practice.

Late Policy

In order to address the needs of all our patients, we kindly ask that patients show up for their appointment 10 minutes early. New patients should arrive 30 minutes early with an insurance card and photo ID. If you are 7 minutes late for your appointment, we will ask you to reschedule.

Cancellation Policy

Please call 24 hours in advance to cancel, or reschedule your appointment. "No shows" without advance notice will be charged a fee of $50. This is to compensate for a time slot that could be used to go to another patient in need of care. Unfortunately, patients with a history of "no shows" may be dismissed from our care.

Patient Conduct Policy

We are committed to treating you with the utmost respect. As healthcare workers, we also ask for your respect and understanding. Raised voices and foul language towards staff are inappropriate and will lead to dismissal from our care.

Follow-Ups & Annual Visit / Wellness Visits Policy

When you are referred for laboratory assessments, imaging or other referrals, we will schedule a follow-up visit in order to go over your results, answer any questions, and work with you to devise the best path forward for your health. This can oftentimes be done by telehealth. These follow-up appointments will be scheduled upon check-out.

Annual "check-up" visits (annual physical / wellness visits) are also very important to document any changes and review and update your care plan. Sometimes, critical health issues are noted at this visit and treated early.

Both follow-up visits and annual check-ups are important to providing the best primary care possible, and patients ought to attend these visits. Patients that have not been seen in the last 2 years will need to re-establish as new patients.

Prescription Refill Policy

If you need a medication refill, we ask that you call your pharmacy first. Oftentimes, there are refills on file with your pharmacy. Please allow 72 hours (3 business days) for your pharmacy to contact our office. Some prescriptions require an office visit or lab work to be completed prior to getting a refill. Prescriptions that are "as needed" that are more than 6 months old will not be renewed without an office visit. We may not be able to refill a prescription if follow-up appointments have not been kept. It is our policy for patients to be seen every 3 to 6 months when on medication, depending on if the condition is uncontrollable and its severity. As a general rule, patients taking narcotic prescriptions for pain may be referred out to a pain specialist or asked to sign a narcotics contract.

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Consent To Use Protected Health Information

Protecting your health information is one of our top priorities. By signing below, you authorize Rio Grande Family Medicine to release all necessary information to my insurance company(s) including information covered under HIPAA. You agree to allow Rio Grande Family Medicine to use your patient information in order to provide treatment to you, and to obtain payment for treatment received, for specific research purposes or conduct practice operations. If you do not wish to be contacted for research opportunities pertaining to your health, you may inform Rio Grande Family Medicine in writing.

If you desire a copy of any records, it will be provided upon request within 72 hours.

Financial Responsibility

We will file your insurance claims to your insurance provider. It is important to keep Rio Grande Family Medicine up to date with any changes to your insurance, including secondary insurance. Without the correct insurance information, claims will not be filled correctly.

Copays are due at the time of appointment. If an outstanding balance is due, the receptionist will collect it during check in before your visit. If you do not have insurance, $85.00 is due at the time of appointment and the remainder will be calculated later. Patients are responsible for paying claims in full that have been denied by their insurance company. You are responsible for providing accurate and up-to-date insurance information and responsible for any charges if you do not.

You are also responsible for knowing whether your insurance is accepted at our clinic. We will do our best to determine eligibility, but there are many varieties of insurance and we might not always be aware if we are contracted or not. If we are not contracted for your particular plan, the balance will be transferred to you as a self-pay.

As a rule, we do not perform medical examinations involving claims filed with personal insurance or a dispute involving attorneys.

Coverage from insurance companies vary depending on policies and the type of medical visit. Typically, physical exams may include a copay or deductible if additional health issues are brought up during the time of the appointment, either by patient or due to the provider's concern. If you have questions about this, please contact your insurance company.

If you are assigned a deductible or coinsurance, this needs to be paid within 30 days unless financial arrangements have been made. Unpaid outstanding balances over 90 days past due will be referred to collections, and you will be responsible for any additional fees incurred. There is a $40.00 service charge on all returned checks.

By signing below, you agree to all of the above policies and to pay all co-pays, deductibles and self-pay charges. If you have any concerns or suggestions, always feel free to share them with your provider or a member of our staff. Thank you.

Signature of patient or guardian Date

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_____
Printed Name

Authorization For Request Of Medical Records

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Rio Grande Family Medicine may verify your identity/guardianship. Some requests may be subject to a reasonable fee.

Patient Information

Last Name _____ First Name _____

Date Of Birth (MM/DD/YYYY) _____ Phone _____

Address _____

City _____ State _____ Zip _____

*Legal representation making request (If other than the patient) _____

Authority of legal representative: ☐ Health Care power of attorney ☐ Health Care Proxy

☐ Guardian ☐ Parent of minor patient ☐ Legal representation of deceased patients estate .

I hereby consent and authorize Rio Grande Family Medicine to, at any time, use a facsimile process or mail to request my medical records from a physician or provider that I have previously seen.

Full name of provider / Facility _____

Date of Request: _____ Date(s) of Service_____ to_____

Information to be released (check all that apply)

☐ My complete medical record

This authorization shall remain in effect for two years or until actual recipient by the Health care provider of a written notice from the patient or legal representative which specifically withdraws and terminates the effect of this authorization, and a photocopy of this fully-executed authorization shall be considered as effective and valid as the original and shall be honored by those to whom it is presented. This authorization shall be promptly made a part of patients permanent medica; records and a copy of this authorization shall accompany the copies of siad confidential records, materials and or/ information released by the Health care provider to the above - named person(s), Party(s), and/or entity(ies).

TO THOSE RECEIVING CONFIDENTIAL RECORDS, MATERIALS AND / OR INFORMATION PURSUANT TO THIS AUTHORIZATION:

This information is released subject to the terms of section 24-2b-7 N.M.S.A (1978 as amended), and this authorization to request records, documentary/tangible material and information is subject to the following statement.

State law prohibits you from making any further disclosures of such information without specific written consent of the person whom the information pertains to or as otherwise, permitted by state law.

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_____ _____
Signature of Patient/Parent/Guardian/Legal representative Date

Authorization For Release Of Medical Records

Patient Name _____ DOB _____

Social Security Number (last 4 digits only): XXX - XX - _____

By signing this form, I authorize Rio Grande Family Medicine, hereinafter the "HEALTHCARE PROVIDER" to release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Full name of provider/facility _____

Address _____

City _____ State _____ Zip _____

Date of request: _____ Date(s) of service _____ To _____

Send by: (choose ONE): ☐ Mail ☐ Fax ☐ Secure email

*Legal Representative making request (If other than the patient): _____

Authority of legal representative: ☐ Health care power of attorney ☐ Health care proxy

☐ Parent of minor patient ☐ Legal representative of deceased patient's estate

This authorization shall remain in effect for two years or until actual receipt by the Health care Provider of a written notice from the patient or legal representative which specifically withdraws and terminates the effect of this authorization, and a photocopy of this fully-executed authorization shall be considered as effective and valid as the original and shall be honored by those whom it is presented. This authorization shall promptly be made a part of the patient's permanent medical records and a copy of this authorization shall accompany the copies of said confidential records, materials and/or information released by the Health care Provider to the above-named person(s), party(ties) and/or entity(ies).

TO THOSE RECEIVING CONFIDENTIAL RECORDS, MATERIALS AND/OR INFORMATION PURSUANT TO THIS AUTHORIZATION.

☐ My complete medical record

This information is released subject to the terms of section 24-2B-7 N.M.S.A> (1978 as amended), and this authorization to request records, documentary/tangible material and information is subject to the following statement .

State law prohibits you from making any further disclosures of information without specific written consent of the person to whom the information pertains or as otherwise permitted by state law.

_____ _____
Signature of Patient/Parent/Guardian/Legal representative Date

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Medical History Questionnaire

Name: _____ Date: ____/____/_____

Address: _____ City: _____ State:____ Zip_____

Birth Date: ___/___/ _____ Last Eye Exam: ___/___/_____

What is your current gender identity? (Please circle all that apply)

☐ Male ☐ Female ☐ I identify as: _____

What sex were you assigned at birth?

☐ Male ☐ Female ☐ Declined to answer

Have you ever had a bone density test? ☐Yes ☐ No If yes, When: ____/_____/_____ ☐ N/A

Result: ☐ Normal ☐Abnormal

Last colonoscopy: _____/____/_____ ☐N/A Where: _____

How often do you exercise? ☐Daily ☐Weekly ☐ Monthly ☐I do not exercise

Types of exercise: _____

Do you wear seatbelts? ☐ Yes ☐ No

Do you consume caffeine? ☐ Yes ☐ No **(If yes, please indicate below):**

Coffee: ☐Yes ☐No How often: _____

Tea: ☐Yes ☐No How often: _____

Soda: ☐Yes ☐No How often: _____

Do you consume alcohol? ☐ Yes ☐ No **(If yes, please indicate below):**

Wine: ☐ Yes ☐ No How often: _____

Beer: ☐ Yes ☐ No How often: _____

Spirits: ☐ Yes ☐ No How often: _____

Do you smoke? ☐Yes ☐No **(If yes, please indicate below):**

Cigarettes: ☐Yes ☐No How often: _____

Vapes/electronic cigarettes: ☐Yes ☐No How often: _____

Cigars: ☐Yes ☐No How often: _____

Chewing tobacco: ☐Yes ☐No How often: _____

Health History (Please mark the ones that apply to you):

Allergies: Yes No **Anxiety:** Yes No **Arthritis:** Yes No **Asthma:** Yes No
Bladder issues: Yes No **Blood clots:** Yes No **Varicose veins:** Yes No
Bronchitis: Yes No

Cancer: Yes No If yes, what kind: _____
Chronic constipation: Yes No Chronic Diarrhea: Yes No Chronic Pain: Yes No
Depression: Yes No Diabetes: Yes No Emphysema: Yes No

Headache: Yes No If yes, please specify type/ pain level: _____

Heart problems: Yes No If yes, what kind: _____

High Blood Pressure: Yes No High Cholesterol: Yes No Joint Pain: Yes No

Hepatitis: Yes No If yes, what type: _____

Liver problems: Yes No Muscle problems: Yes No Kidney problems: Yes No
Lung problems: Yes No Osteoporosis: Yes No Prostate problems: Yes No
Seizures: Yes No Substance abuse: Yes No Thyroid problems: Yes No
History of tb/Positive Skin test: Yes No Ulcers: Yes No Reflux: Yes No

Heartburn: Yes No Other, please specify: _____

Do you see any specialists? If yes, please provide details below:

_____

_____

Have you been diagnosed with any new conditions? Yes No If yes, please explain:

_____

_____

Female Patients:

Last Mammogram: ____/____/_____ Where: _____
Result: ☐Normal ☐Abnormal

Last PAP: ____/____/_____ Where: _____

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Result: ☐Normal ☐Abnormal

Last menstrual Period: ____/____/_____ Menstrual Problems: _____
Pregnancies: ____ Births: ____ Miscarriages or abortions: ____

Contraception: ☐Yes ☐No If yes, what method do you use? _____

Menopause: ☐Yes ☐No Year started: _____ Do you/did you take hormones? ☐Yes ☐ No
If yes, please explain: _____

Medical History:

Hospitalization / Surgical History:	Date:

Family History:

Relative:		Health Issues:
Mother	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Father	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Son	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Daughter	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Brother	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Sister	Living? ☐Yes ☐No Age:____	

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	Deceased? ☐Yes ☐No	
Maternal Grandmother	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Maternal Grandfather	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Paternal Grandmother	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	
Paternal Grandfather	Living? ☐Yes ☐No Age:____ Deceased? ☐Yes ☐No	

Current Medication List:

Medication:	Dosage and frequency:	Indication:

Pharmacy Information:

Name of Pharmacy:	Address/Location:	Phone:

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Allergies:

Type of Allergy:	Reaction:

Anything else that you would like your provider to know about: