Medical Associates of Northern New Mexico, PA

3917 West Road, Suite A, Los Alamos, NM -87544-
Tel: (505) 661-8900
Fax: (505) 661-8916
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PATIENT INFORMATION

In order to serve you properly, it is important to have the following information. **Please Print.** All information will be confidential.

Today's Date: _____ (mm/dd/yy)
Patient's Name: _____ **SSN:** _____ - _____ - _____
Email Address:_____
Male_____ Female_____ **Date of Birth:**_____ **Main Contact Phone:**_____
Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Address (if different): _____ **City:**_____ **State:**_____ **Zip:**_____
Make Appropriate Selection: Minor____ Single____ Married_____ Separated_____ Divorced_____ Widowed_____
Patient's Employer:_____ Work Phone:_____
Spouse's OR Parent's Name:_____ Employer:_____ Home Phone:_____
Referring MD:_____ PCP:_____
Emergency Contact:_____ **Relationship:**_____ **Home Phone:**_____

RESPONSIBLE PARTY (If different from patient)
Name of Person Responsible for This Account:_____ Relationship to Patient:_____
DOB:_____ **SSN:** _____ - _____ - _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Address (if different): _____ City:_____ State:_____ Zip:_____
Employer:_____ Work Phone:_____ Home Phone:_____

INSURANCE INFORMATION
Insurance Company:_____ **Group #:**_____ **ID #:**_____
Address of Insurance Company:_____
_____Check here if all the information below is the same as the "RESPONSIBLE PARTY".
Name of Insured:_____ Relationship to Patient:_____ DOB:_____ SSN:_____
Name of Employer:_____ Phone:_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____YES _____NO If "Yes", please complete the following.
Insurance Company:_____ **Group #:**_____ **ID #:**_____
Address of Insurance Company:_____
Name of Insured:_____ Relationship to Patient:_____ DOB:_____ SSN:_____
Name of Employer:_____ Phone:_____

PLEASE LIST MEDICATION ALLERGIES:_____
WHAT KIND OF REACTIONS? _____
I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also authorize payment of insurance benefits directly to Medical Associates of Northern New Mexico.

_____
Signature of Patient, or Parent, if Minor

Medical Associates of Northern New Mexico

Patient Personal History

Confidential Record: Information contained will not be released except when you authorize us to do so

MR#_____

Name:_____ _____ **Date**_____

Last **First** **MI** **Nickname**

My last complete physical exam was done in (year) _____ by _____

Family History:

Family History	Year of Birth	Illnesses	Age at Death	Cause of Death
Father				
Mother				
Brothers/Sisters				
#1 M or F				
#2 M or F				
#3 M or F				
#4 M or F				
#5 M or F				
Children				
#1 M or F				
#2 M or F				
#3 M or F				
#4 M or F				
#5 M or F				

❑ **More siblings/children listed on attached sheet**

Check if you or any *close blood relatives* (other than those mentioned above) have or had any of the following:

❑ Heart disease	❑ Unusual bleeding after surgery or dental work	❑ Depression/Nervous breakdown
❑ Stroke	❑ Asthma	❑ Alcoholism
❑ High blood pressure	❑ Stomach or intestinal problems	❑ Migraine headaches
❑ High cholesterol	❑ Thyroid disease	❑ Arthritis
❑ Diabetes	❑ Epilepsy	❑ Kidney disease
❑ Cancer/tumor		❑ HIV Infection

Past Medical History:

Surgeries/Hospitalizations (women exclude normal deliveries):_____

_____

_____

List any other serious illnesses or injuries you have bad: _____

_____

_____

Patient Personal History (cont'd)

Prescription Medications Over-the-counter Drugs Herbal Preparations	Dose or Strength	How often do you take this medication?	How long have you been taking this medication?	What do you take this medication for?

❑ **More medications listed on attached sheet**

Medication allergies:_____

Potential areas for stress:

Where do you work?_____ What is your occupation? _____

Who lives in your household?_____

Any marital problems?_____

Any financial problems?_____

Does anyone in your household have drug or alcohol problems?_____

What are your biggest life stressors at this time?_____

Recreation:

What do you do for recreation/relaxation?_____

Habits/Risk Factors:

Tobacco use: ❑ Age started _____ Age stopped_____ ❑ Cigarettes_____ Cigars_____ Pipe_____ ❑ Smokeless tobacco/snuff How long_____	Coffee/Tea ❑ Cups per day_____ ❑ Caffeinated ❑ Decaffeinated
Alcohol use: ❑ None ❑ Seldom ❑ Regularly ❑ Occasionally excessive ❑ Have sought help	Drug use: ❑ None ❑ Seldom ❑ Regularly ❑ Occasionally excessive ❑ Have sought help
Sexuality: ❑ Heterosexual (straight) ❑ Homosexual (gay) ❑ Bisexual (both)	Sexuality: ❑ Multiple sexual partners in last year ❑ Sexual partners who had Hepatitis B, were intravenous drug users, or prostitutes

Habits/Risk Factors (cont'd)

Safety: ❑ Use seat belts in vehicles ❑ Smoke detectors in home ❑ Carbon monoxide detectors in home	Exercise: ❑ Exercise regularly ❑ _____ time per week
Work History: ❑ History of working in mines ❑ Current or past exposure to a lot of dust, asbestos, or chemicals	

REVIEW OF SYSTEMS: Please check any condition you are experiencing or have experienced.

Constitutional: ❑ Unexplained weight loss ❑ Change in appetite ❑ Sleeping difficulty ❑ Fevers/sweats ❑ Loss of energy	Genito-urinary (GU) ❑ Burning or pain with urination ❑ Increased frequency of urination ❑ How often do you get up at night to urinate? ___ times ❑ Unable to control bladder ❑ Blood in urine ❑ Unable to start stream or weak stream ❑ Any venereal/sexually transmitted disease ❑ Kidney stones
Skin: ❑ Rashes or changes in color ❑ Persistent itching ❑ Moles that have changed ❑ Bruise easily	Musculo-skeletal: ❑ Pain in bones or joints ❑ Muscle pain ❑ Joints that swell ❑ Phlebitis or inflamed leg veins
Eyes: ❑ Loss of vision ❑ Blurring or double vision ❑ Eye pain	Endocrine: ❑ Thyroid problems
Ears, Nose, Throat (ENT): ❑ Hearing loss ❑ Ringing in ears ❑ Ear pain ❑ Frequent nosebleeds ❑ Sinus trouble ❑ Constant nasal congestion or runniness ❑ Persistent sore throat ❑ Voice changes or hoarseness ❑ Trouble swallowing ❑ Bleeding gums	Gastrointestinal (GI): ❑ Nausea/vomiting ❑ Vomited blood or "coffee ground" material ❑ Heartburn or indigestion ❑ Abdominal pain ❑ Constipation or diarrhea ❑ Bloody or black bowel movement ❑ Changes in bowel movements ❑ Pain during or after bowel movement ❑ Yellow jaundice ❑ Hemorrhoids
Respiratory: ❑ Chronic cough ❑ Wheezing ❑ Blood in sputum/phlegm ❑ Exposure to TB ❑ Positive TB test ❑ Shortness of breath o Doing your usual work o Climbing a flight of stairs o Awakens you at night o Causes you to cough Accompanied by wheezing	Cardiovascular: ❑ Pain, tightness or heaviness in your chest o When exerting yourself o When upset or excited o Radiates down the arm o Disappears if you rest ❑ Rapid, slow or irregular pulse ❑ Sleep on more than one pillow ❑ Rheumatic fever/heart murmur ❑ Calf pain when walking ❑ Ankle swelling

Neurologic:	Emotional:
❑ Dizzy spells ❑ Recurrent headaches ❑ Memory loss ❑ Seizures or convulsions ❑ Blindness of one eye ❑ Weakness in any part of your body ❑ Numbness in any part of your body	❑ Feel nervous often ❑ Feel "down in the dumps" often ❑ Worry a lot ❑ Loss of interests ❑ Loss of energy or ambition ❑ Considered suicide ❑ Rate sex life Poor 1 2 3 4 5 Excellent
Men: ❑ Diminished sexual activity ❑ Discharge from penis ❑ Hernia ❑ Prostate trouble	Women: ❑ Last period_____ ❑ Last Pap smear_____ ❑ Last mammogram_____ ❑ Diminished sexual activity ❑ Bleeding after intercourse ❑ Pain with intercourse ❑ Difficulties with periods ❑ Recent vaginal discharge ❑ Current method of birth control_____ ❑ Number of pregnancies_____ ❑ Number of miscarriages_____ ❑ Bleeding after menopause ❑ Hot flashes ❑ Breast lump ❑ Breast pain

Preventive Medicine

Immunizations: I had my last vaccine in (please enter year):	Screening Exams: I had the following screening exams in (please enter year):
❑ Tetanus_____ ❑ Pneumonia_____ ❑ Hepatitis A_____ ❑ Hepatitis B_____	❑ Bone density_____ ❑ Colonoscopy/colon cancer screening_____ ❑ Prostate cancer screening (Males only)_____ ❑ Dental exam_____

Describe briefly your present medical problems and symptoms:

_____
_____
_____
_____
_____
_____

_____ _____

Patient's Signature Date

MANNM MEDICAL ASSOCIATES OF NORTHERN NEW MEXICO, P.A.

Cardiology, Nephrology, Endocrinology, Internal Medicine & Family Practice

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Resident Name: _____ Date of Birth:_____
Address:_____

I have been given a copy of Medical Associates of Northern New Mexico's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Medical Associates of Northern New Mexico has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Medical Associates of Northern New Mexico web site at www.mannm.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____
Signature of Resident or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor-of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:
   _____
   _____
2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement*:
   _____
   _____

\Completed by:

_____
Signature of Facility Representative Date

_____
Print Name

File original in resident's Business Office Record

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____ DOB:_____ Acct#:_____

Please check all that apply and list name(s) of spouse, child(ren), and others involved in care as applicable.

NAME/RELATIONSHIP	ADDRESS/PHONE	PHI PERMISSIONS
		o Permission to speak/discuss medical care/test results o Permission to access paper/electronic records
		o Permission to speak/discuss medical care/test results o Permission to access paper/electronic records
		o Permission to speak/discuss medical care/test results o Permission to access paper/electronic records

I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Name:_____ **DOB:**_____

Signature:_____ **Date:**_____