MAIN STREET MEDICAL CENTER

Red River, NM **Jessica Cross, FNP-BC**

What is the purpose of your visit today? _____

Please complete **all sections** of this form. If a section is not applicable, please mark as N/A to acknowledge you have reviewed that section. Sign all indicated areas.

PATIENT INFORMATION

First Name Middle Last Name Date of birth

_____

Social Security # Sex Marital Status

_____

We are required by the Federal Government to ask and collect information on race, ethnicity, employment status and language preferences.

Race

☐ I decline to report
☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:_____

Employment Status

☐ Employed ☐ Not Employed ☐ Retired

INSURANCE

Please proved a copy of your insurance card and your identification card (photo id). If you do not have a copy of your card we cannot bill your insurance. You may reschedule your appointment or elect to pay as a "non-insured" patient.

☐ I **don't have** health insurance and will provide payment for services rendered today.

☐ I **have** insurance and I am the Primary (main person) Insured

☐ I **have** insurance and I am a dependent (not the main person) on this policy

PRIMARY INSURANCE

Carrier (Aetna, BCBS, Medicare, ect) Identification Number Group Number

_____

**If dependent, please provide:*
Primary insured Name *Address* *Date of Birth*

_____

SECONDARY INSURANCE

Carrier (Aetna, BCBS, Medicare, etc.) Identification Number Group Number

_____

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*If dependent on secondary insurance, please provide

Primary insured Name Address Date of Birth

_____

***Please make sure your primary and secondary are in correct order! Having this information entered incorrectly will delay payment from insurance, and possibly cause you to be financially responsible for the bill (see our Financial Responsibility Statement).*

(Patient) ADDRESS(es)

Primary Address (address associated with Insurance Policy; permanent address)

Mailing address City State Zip-code

_____

Secondary Address (address you would like to receive mail regarding your account, if different that your primary address).

Mailing address City State Zip-code

_____

I certify that I am presenting a VALID, active coverage insurance card.

_____

Signature Date Print

Contact Phone Numbers

Cell: _____ Home: _____

Work: _____ Other:_____

Email address _____

You will be sent a link to our online portal, where you can access certain parts of your medical records. You can update your medical history, medication list, address and insurance information. You will also be able to schedule appointments, securely communicate with our staff, and request medication refills.

COMMUNICATION PREFERENCE

You will receive communications from the practice for various functions such as appointment confirmations, appointment recalls, reminders when test results are received and health maintenance reminders. Please associate your preferred communication method(s) for each of these functions and your order of preference.

1. _____
2. _____
3. _____

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IMMUNIZATIONS

☐ Immunizations are current

Immunizations received as an adult:

Influenza – date _____

Tetanus- date _____

Tetanus with Whopping cough (Tdap) date _____

Hepatitis A series – date _____

Hepatitis B series – date _____

Pneumococcal (PPV13 or PPV23) date _____

Zoster (shingles) date_____

MEDICAL HISTORY

☐ No significant medical history

☐ Alcoholism
☐ Allergies / hayfever
☐ Anxiety
☐ Asthma
☐ Anemia (type) _____
☐ Arthritis
☐ Atrial fibrillation
☐ Arthritis
☐ Blindness
☐ Bipolar disorder
☐ Blood Clots (DVTs)
☐ Cataracts
☐ Chronic pain (location)_____
☐ Cancer (where/type)_____
☐ Celiac disease / gluten intolerance
☐ Chronic bronchitis
☐ COPD (chronic obstructive pulmonary disease)
☐ CHF (congestive heart failure)
☐ Chronic sinus infections
☐ Cancer: (type) _____
☐ Diabetes type 1
☐ Diabetes type 2
☐ Depression
☐ Epilepsy
☐ Glaucoma
☐ Gall stones
☐ GERD (gastroesophagel reflux)
☐ Gout
☐ Hearing aids
☐ Hepatitis, type _____
☐ Hernia (where) _____
☐ HIV
☐ Headache(s)
☐ History of Head injury
☐ Heart attack
☐ Herniated disc
☐ Hearing loss
☐ Heartburn
☐ High blood pressure (hypertension)
☐ High cholesterol
☐ Hypothyroidism (under active)
☐ Hyperthyroidism (over active)
☐ Insomnia
☐ Irritable bowel syndrome
☐ Kidney failure / kidney disease
☐Lung disease
☐ Migraine(s)
☐ Obstructive sleep apnea
☐ Osteoarthritis
☐ Osteoporosis (brittle bones)
☐ Skin disorder
☐ Stroke
☐ Seizures
☐ Stroke
☐ Stomach ulcer
☐ TIAs (transient ischemic attacks)
☐ UTIs (urinary track infections)
☐ Wears glasses / contact
☐ Other _____

Other important medical history I want to share (not surgeries! That's the next page…)

_____

_____

_____

_____

_____

_____

_____

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SURGERIES

☐ No surgical history

Date

☐ Adenoidectomy _____

☐ Appendectomy _____

☐ Breast implants _____

☐ Cesarean section _____

☐ Cholecystectomy _____

☐ Coronary artery bypass _____

☐ Discectomy _____

☐ Ear tubes _____

☐ Hernia repair _____

Date

Heart valve replacement _____

Hip replacement _____

Hysterectomy _____

Knee surgery _____

Laminectomy _____

Tonsillectomy _____

Resection of prostate _____

Other: _____

_____

_____

FAMILY HISTORY

☐ No known family history

*Indicate beside condition, **M** (mother), **D** (dad), **S** (sister), **B** (brother), **GM** (grandmother), **GF** (grandfather), or **C**(child)

_____ Alcoholism
_____ Allergies / hayfever
_____ Anxiety
_____ Asthma
_____ Anemia
_____ Arthritis
_____ Atrial fibrillation
_____ Arthritis
_____ Blindness
_____ Bipolar disorder
_____ Blood Clots (DVTs)
_____ Chronic pain
_____Cancer (where/type)_____
_____ Celiac disease
_____ Chronic bronchitis
_____ COPD (chronic obstructive pulmonary disease)
_____ CHF (congestive heart failure)
_____ Cancer: (type) _____
_____ Diabetes type 1
_____ Diabetes type 2
_____ Depression
_____ Epilepsy
_____ Glaucoma
_____ Gall stones
_____ Gout
_____ Hepatitis, type _____
_____ HIV
_____ Headache(s)
_____ Heart attack
_____ Herniated disc
_____ High blood pressure
_____ High cholesterol
_____ Hypothyroidism
_____ Hyperthyroidism
_____ Insomnia
_____ Irritable bowel
_____ Kidney failure / kidney disease
_____ Lung disease
_____ Migraines
_____ Obstructive sleep apnea
_____ Osteoarthritis
_____ Osteoporosis
_____ Skin disorder
_____ Stroke
_____ Seizures
_____ Stroke
_____ Stomach ulcer
_____ TIAs
Other _____

_____

_____

MEDICATIONS

☐ Patient is not currently taking any medications ☐ List provided

Medication Name **dose (mg strength)** **how many times daily**

_____

_____

_____

_____

_____

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ALLERGIES

Please list all allergies, the reaction you experienced and severity.

Name	**Reaction**	**Severity**

SOCIAL HISTORY

☐ Never smoked ☐ Smoker ☐ Current "some-day" smoker ☐ Former smoker – year quit _____

Do you drink alcohol? ☐ Yes ☐ No **Type**: ☐ Beer ☐ Wine ☐ Liquor **Number of drinks** _____ ☐ daily ☐ weekly ☐ monthly

Illicit drug use: ☐ No ☐ Yes (type)_____

CONSENTS & PATIENT POLICIES

We cannot and *will not* see you unless you have agreed to our policies.

PRIVACY POLICY: I have read, and / or been offered a copy of Main Street Medical Center's Privacy Policy. I hereby acknowledge and accept all aspects of their privacy policy. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Privacy policy on behalf of the patient.

_____

Signature Date Print

***PRACTICE ASSIGNMENT OF BENEFITS AGREEMENT*:** I hereby acknowledge and accept all aspects of Main Street Medical Center's Practice Assignment of Benefits Agreement. A copy of the Practice Assignment of Benefits Agreement has been provided to me for my review. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Practice Assignment of Benefits on behalf of the patient.

_____

Signature Date Print

***FINANCIAL RESPONSIBILITY STATEMENT*:** I hereby acknowledge and accept all aspects of the Main Street Medical Center's Financial Responsibility Statement. A copy has been provided to me for my review. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Financial Responsibility Statement on behalf of the patient.

_____

Signature Date Print

ONLINE & E-SCRIBING DRUG CONSEN: I hereby acknowledge and accept all aspects of the Main Street Medical Center's online e-scribing and drug consent policies. A copy has been provided to me for my review. If I am the guardian, parent, or caregiver of the patient, I accept responsibility for agreeing to the Online & E-scribing consent on behalf of the patient.

_____

Signature Date Print

*You may request a copy of any / all policies for your records. You may also review these policies at any time on our website