Vanessa's Family Clinic & Med Spa

402 East Wood Avenue

Phone:(575) 941-2500

Fax: (575) 941-2503

Email: Vfc5pcp2outlook.com

Website: VanessasFamilyClinic.com

Vanessa Green, FNP
Patricia Shepard, FNP
Nicole Chavez, FNP
Amy Chavez, FNP

Office Hours

Monday-Wednesday
8:00-12:00 – 1:00–5:00
Thursday
8:00-12:00 – 1:00-4:00
Friday
8:00 – 12:00

Payment Policy

All Co-Pays and deductibles are due at the time of service.

Prescription Refills

Please call your pharmacy and ask for refills at least 3 days before you run out of medication.

Registration Form

This form *MUST* be filled out completely and signed, if it is incomplete an appointment will not be made.

Registration Form

Please Print

MUST FULLY COMPLETE PACKET, FAILING TO DO SO MAY RESULT IN BEING DENIED AS A PATIENT

Today's Date:				**PCP:**
Last Name: **First:** **Middle:**			**Mr./ Mrs./Miss**	**Marital Status: Single/ Mar / Div. / Sep. / Wid.**
Is this your legal name? Yes No	**If No, Legal Name?**	**Former Name?**	**Birthday: / /**	**Age: Sex: M or F**
Street Address:		**Social Security #**		**Home/Cell Phone**
PO BOX	**City:**		**State:**	**Zip Code:**
Occupation:		**Employer:**		**Employer Phone #:**
PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK FOR A COPY				
Person Responsible for Bill:	**Birthday: / /**	**Address: (If different)**		**Home/ Cell Phone:**
Is This Person a Patient Here? Yes or No?				
Subscriber's Name:		**Subscribers Social Security #**		**Subscribers Birthday / /**
Primary Insurance Name:	**Group #**	**Policy #**		**Co-Payment: $**
Patient's Relationship to Subscriber: Self Spouse Child Other				
Secondary Insurance Name:	**Subscribers Name:**		**Group #**	**Policy #**
Patient's Relationship to Subscriber: Self Spouse Child Other				
Emergency Contact (not living with you):	**Relationship to Patient:**		**Home/Work Phone #:**	
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Vanessa's Family Clinic, Inc. or insurance company to release any information required to process my claims. By signing below, I authorize treatment at this office.				
Patient/Guardian Signature:				**Date:**
Email Address:				

Vanessa's Family Clinic & Med Spa

Health History

Name:_____ Today's Date:_____

DOB:_____ Age:_____ Date of Last Physical Examination:_____

What is your reason for today's visit?_____

Place a checkmark next to symptoms you have or have had in the last year:

General

☐ Chills
☐ Depression
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of Sleep
☐ Nervousness
☐ Numbness
☐Sweats

Gastrointestinal

☐ Poor Appetite
☐ Bloating
☐ Bowel Changes
☐ Constipation
☐ Diarrhea
☐ Excessive Thirst
☐ Gas
☐ Hemorrhoids
☐ Excessive Hunger
☐ Indigestion

Eye/Ear/Nose/Throat

☐ Bleeding Gums
☐ Blurred Vision
☐ Crossed Eyes
☐ Diff. Swallowing
☐ Double Vision
☐ Earache
☐ Ear Discharge
☐ Hay Fever
☐ Hoarseness
☐ Hearing Loss

Men Only

☐ Breast Lump
☐ Erection Diff.
☐ Lump in Testes
☐ Penis Discharge
☐ Sore on Penis

Women Only

☐ Abnormal Pap
☐ Abnormal Bleeding
☐ Breast Lump
☐ Extreme Menstrual Pain
☐ Hot Flashes
☐ Painful Intercourse
☐Vaginal Discharge
Last Period_____
Last Pap_____
Last Mammo_____
Are you Pregnant?____
Number of Children___

PLEASE ANSWER ALL

Genitourinary

☐ Blood in Urine
☐ Frequent Urination
☐ Bladder Control
☐Painful Urination

Muscle/Joint/Bone

Pain/Weakness/Numbness
☐ Arm/Hands/Legs
☐ Back//Neck/Shoulder

Cardiovascular

☐ Chest Pain
☐ High Blood Pressure
☐ Irreg. Heart Beat
☐Low Blood Pressure
☐Ankle Swelling
☐Poor Circulation
☐ Varicose Veins
☐ Fast Heartbeat

Skin

☐ Bruise Easy
☐ Hives
☐Itching
☐Change in Moles
☐ Rash
☐Non-healing Wound

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Health History

(Confidential)

THIS SECTION MUST BE COMPLETED

PREVIOUS/CURRENT DOCTORS/SPECIALISTS SEEN:

_____

_____

_____

_____

ALLERGIES/REACTIONS TO MEDICATIONS:

_____

_____

_____

_____

PHARMACY NAME:

_____

PHARMACY PHONE NUMBER:

_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY PROVIDER OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____

Signature Date

Relationship	Age	Health	Death	State of Age/Cause of Death
Father				
Mother				
Brother				
Sister				

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Check what substance you use and how frequently:			**Check if applicable:**	
	Caffeine			**Stress**
	Tobacco			**Hazardous Substance**
	Drugs			**Heavy Lifting**
	Alcohol			**Other**
	Other			**Your Occupation:**

CONDITIONS: Place a checkmark next to the symptoms that you currently have or had within the last year.

☐ Aids	☐ Bulimia	☐ Gonorrhea	☐ Measles	☐Psych. Care
☐ Alcoholism	☐Cancer	☐ Gout	☐ Migraines	☐ Rheumatic Fever
☐Anemia	☐ Cataracts	☐ Heart Disease	☐ Miscarriage	☐ Scarlet Fever
☐ Anorexia	☐ Chicken Pox	☐ Hepatitis	☐Mononucleosis	☐ Stroke
☐ Appendicitis	☐ Diabetes	☐ Hernia	☐ MS	☐ Suicide Attempt
☐ Arthritis	☐ Drug Abuse	☐ Herpes	☐ Mumps	☐ Thyroid Problem
☐ Asthma	☐ Emphysema	☐High Cholesterol	☐ Pacemaker	☐TB
☐ Bleeding Disorders	☐Epilepsy	☐ HIV	☐ Pneumonia	☐Typhoid Fever
☐ Breast Lump	☐Glaucoma	☐Kidney Disease	☐ Polio	☐ Ulcers
☐ Bronchitis	☐ Goiter	☐ Liver Disease	☐ Prostate Prob.	☐ Vaginal Prob.

THIS SECTION MUST BE COMPLETED

MEDICATIONS:	DOSE:	FREQUENCY:

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FAMILY HISTORY

CHECK/CIRCLE IF ANY OF YOUR BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING:

DISEASES:		RELATIONSHIP TO YOU:
	Arthritis (RA, OA, Gout)	
	Asthma, Allergies, Hay Fever	
	Cancer (SPECIFY)	
	Drug Dependency	
	Diabetes	
	Heart Disease, High Blood Pressure	
	Stroke	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATION:			PREGNANCY HISTORY:		
YEAR:	HOSPITAL:	REASON & OUTCOME	YEAR	SEX	COMPLICATIONS

SERIOUS ILLNESS/INJURY:	DATE:	OUTCOME:

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The following information is provided to avoid any misunderstanding or disagreements concerning payment for professional services.

- **Prompt payment allows us to control costs. Outstanding accounts cost both you and me time and money. Therefore, all Co-Pays, Co-Insurances, and self-pay amounts are due at time of service.**
- **Under no circumstance will our office make payment arrangements on balances insured because of the insurance paying you directly. If you should receive a payment for a claim filed by our office, you will need to forward the payment directly to our office.**
- **Our practice firmly believes that a good provider/patient relationship is based on understanding and open communication. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you may have concerning a balance.**

If you have any questions concerning our policy or need assistance, please contact us immediately.

Signature:_____ Date:_____

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ACKNOWLEDGEMENT OF ADVANCE DIRECTIVES

Do you have a Living Will (Right to Die) Document? Yes or No

Do you have a Durable Power of Attorney for health care decisions? Yes or No

Name of the individual with Durable Power of Attorney:_____

If yes was answered to either of the above questions, please have a copy of your Living Will and/or Durable Power of Attorney delivered to Vanessa's Family Clinic to be filed in our medical records.

I, _____, acknowledge that I have received a copy of the Advance Directive Brochure.

I, _____, am not interested in the information of Advance Directive.

Signature of Patient/Informant:_____

Relationship to Patient:_____

Staff Signature:_____ Date:_____

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I AUTHORIZE VANESSA'S FAMILY CLINIC TO RELEASE ANY OF MY MEDICAL INFORMATION TO THE FOLLOWING:

NAME:_____

RELATIONSHIP TO ME:_____

DATE OF BIRTH:_____ PHONE NUMBER:_____

NAME:_____

RELATIONSHIP TO ME:_____

DATE OF BIRTH:_____ PHONE NUMBER:_____

NAME:_____

RELATIONSHIP TO ME:_____

DATE OF BIRTH:_____ PHONE NUMBER:_____

I WANT A RESTRICTION ON THE ABOVE MEDICAL INFORMATION RELEASED; PLEASE DO NOT RELEASE ANY OF MY MEDICAL INFORMATION REGARDING:

_____
_____
_____
_____

THIS AUTHORIZATION WILL BE IN EFFECT UNTIL I NOTIFY VANESSA'S FAMILY CLINIC, INC. IN WRITING THAT I WANT TO TERMINATE THIS AUTHORIZATION.

SIGNATURE:_____ DATE:_____

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Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware that the medical practices and offices may use an electronic prescription system that allows prescriptions and related information to be electronically sent between my provider and my pharmacy.

I have been informed and understand that my provider, using the electronic prescribing system, will be able to see information about medications that I am already taking, including those prescribed by other health care providers.

I give my consent to my provider to see this health information.

_____ _____

Parent, Patient, or Authorized Representative **Date**

_____ _____

Relationship to Patient **Witness Signature**

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Due to the increase in NO-SHOWS, we will be enforcing the $50.00 no-show fee. If you do not call 4 hours prior to your appointment to cancel or reschedule, you will be charged $50.00. Please DO NOT rely on the automated reminder phone call for your appointment. It is a courtesy we provide, but it is NOT always reliable. If you no-show an appointment due to not receiving a reminder call, you WILL STILL be charged and expected to pay a no-show fee! If you accumulated 3 No-Show fees, you will be terminated from Vanessas Family Clinic. Also if you are late 10 minutes or more, you will be considered a No-Show and will be charged accordingly. Please be considerate of the other patients; cancelling ahead of time allows the Providers to see other patients in a timely manner.

Signature:_____ Date:_____

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Phone: (575 941-2500 Fax (575) 941-2503

Patient:_____ Date of Birth:_____

I Herby grant_____,

(Name of Organization authorized to release information)

_____ Medical Records

_____Labs

_____Progress Notes

_____ Testing Results

_____Social History

_____ Treatment Plan

_____ Consultations

_____ Evaluations

_____ Discharge Summary

_____ Alcohol/Drug Testing

_____ HIV/AIDS

_____ Other

The above information is to be released/exchanged with:_____

The purpose for release of information is _____

This authorization is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance herein, and if not earlier revoked, it shall be terminated 90 days from the date without express revocations. Exception: Exchanged of Information is valid while care is active, but not to exceed one year.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Staff Signature:_____ Date:_____

IF REVOCATION IS DESIRED:

Patient Signature:_____ Date:_____

Staff Signature:_____ Date:_____

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part2) prohibit you from making any further of it without consent of the person to whom it pertains, or as otherwise permitted by law. A General authorization for the release of medical or other information is not sufficient for this matter.