

Alma Family Medicine
460 St. Michael's Dr., Ste. 1104
Santa Fe, NM 87505
505-820-2562

NEW PATIENT INFORMATION

CONFIDENTIAL INFORMATION

Full Legal Name _____ / _____ / _____
Last Name First Name MI

Date of Birth _____ Social# _____

Address _____ / _____ / _____ / _____
Street #/PO Box City State Zip

Telephone # _____ / _____ / _____
Home Work Cell

Which number would prefer to be contacted for appointments or test results: Home Work Cell

Email address _____

Preferred Pharmacy _____

Emergency Contact Name and Phone Number _____

Insurance Co. _____ ID# _____

Medical History (ex: high blood pressure, diabetes, heart disease, etc): _____

Surgical History and year it was done (ex: tonsillectomy, appendectomy, etc): _____

Allergies to Medications:

Medication:	What the reaction was:

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Medications:

Name of Medication:	Dose:	How often you take it:

Social History:

Do you smoke, are you a former smoker? _____

How many times per week to you exercise? _____

Do you drink alcohol and if so how much? _____

Do you use illicit drugs? _____

Education: _____

Occupation: _____

Are you married/partnered? _____

Any children? How many? _____

Family History:

Medical Problem:	Which family member(s) (please include maternal or paternal side)
Diabetes	
Heart Disease	
Cancer	
Stroke	

Health Maintenance:

Medical Test:	Approximate date it was last done:
Physical Exam	
Bloodwork	
Colonoscopy	
Mammogram	
Bone Density Test	
Tetanus Vaccine	
Shingles Vaccine	
Pneumonia Vaccine	
Pap smear	

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460 St. Michael's Dr., Ste. 1104
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Phone: 505-820-2562
Fax: 505-795-7123

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name _____

Date of Birth _____

Phone Number _____

Please transfer my records to Alma Family Medicine From:

Name of previous physician _____

Address _____

Phone _____

Fax _____

Specific Description of Information to be sent (check all that apply)

- ☐ All of my medical records
- ☐ Immunization records only
- ☐ HIV related information that may be in my record
- ☐ Mental Health information that may be in my record
- ☐ Substance abuse information that may be in my record

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Alma Family Medicine, except to the extent that Alma Family Medicine already has taken action based upon my authorization. Unless otherwise revoked, this authorization will expire 6 months from the date of signature. A copy of this form is available to me upon my request. I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accepted all of the above terms.

Signature of individual _____

Date of Signature ____/____/____

ALMA FAMILY MEDICINE POLICIES

Broken Appointments

All patients will be charged a broken appointment fee of \$75.00 if they do not cancel their appointment at least 24 hours prior to the appointment. This fee also applies to a patient not showing up for their appointment. The providers will have the option to waive said fee if they feel the situation that caused the patient to miss or cancel an appointment was an emergency.

Insurance Billing

- If you would like us to bill your insurance, we will bill them based on the information provided to us
- You are responsible for all co-payments, deductibles and other adjustments such as co-insurance payments by your insurance carrier
- You are responsible for and will be billed for any resulting unpaid balance.

Payments

Your payment options are cash, check, credit cards (Visa, Master Card, Discover)

Staff

We at Alma Family Medicine expect the patients to treat all staff members courteously and respectfully.

Providers

The providers share patients. Dr. Kingston is not always available so patients are expected to see the physician assistants when she is booked.

Authorization to Release Medical Records

Any patients, medical practices, hospitals or attorney's offices requesting medical records on a patient need to submit a signed Authorization to Release Medical Information. All new and existing patients are required to sign a release. Information cannot be released to a family member, unless the patient is a minor, unless said release is signed.

Narcotic Prescriptions

All patients who are taking narcotics will be expected to have an office visit every three months in order to refill narcotic prescriptions. If they do not schedule an appointment no refills will be given until they do so.

Past Due Accounts

Accounts greater than 90 days overdue will be sent to a collection agency.

Signature _____ **Date** _____