ALMA FAMILY MEDICINE
460 St. Michael's Drive Suite 1104
Santa Fe, New Mexico 87505
Phone: (505) 820-2562 Fax: (505) 795 7123

Please complete all sections as thoroughly as possible. This information is confidential and will assist your healthcare provider in delivering the best care possible.

PATIENT DEMOGRAPHICS

Full Legal Name (as it appears on your insurance card):

_____/_____/_____
Last Name ***First Name***

Date of Birth (MM/DD/YYYY): _____ Age: _____

Sex at Birth: ☐ Male ☐ Female Gender Identity / Pronouns: _____

CONTACT INFORMATION

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____Preferred Contact Method: ☐ Phone ☐ Text ☐ Email

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EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone Number: _____

PERFERRED PHARMACY: _____

INSURANCE INFORMATION (If you have your current insurance card with you today, you do not need to complete this section)

Primary Insurance Company: _____

Policy Holder Name: _____

Policy Number: _____ Group Number: _____

Secondary Insurance (if applicable/ RX card) _____

COMPREHENSIVE MEDICAL HISTORY

Please list **all current medical conditions**, past illnesses, hospitalizations, surgeries, or significant injuries (include

COVID VACCINE NO ☐ YES ☐ **Approx. Date** _____

FLU VACCINE NO ☐ YES ☐ **Approx. Date**_____

CURRENT MEDICATIONS, VITAMINS & SUPPLEMENTS

Include prescription medications, over-the-counter medications, vitamins, and herbal supplements.

Medication	***Dose***	***Frequency***	***Prescribing Provider***

ALLERGIES & ADVERSE REACTIONS

☐ No known allergies

If yes, list medication, food, or environmental allergies and reactions:

Medications:	***Reaction***

FAMILY MEDICAL HISTORY

Please list any significant family medical conditions and the affected family member(s):

Medical Problem	**Which Family member(s) maternal or paternal side?**
Diabetes	
Heart Disease	
Cancer	
Stroke	
Hypertension	

SOCIAL & LIFESTYLE HISTORY

Occupation: _____

Tobacco Use: ☐ Never ☐ Former ☐ Current
If yes, type and amount: _____

Alcohol Use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Recreational Drug Use: ☐ No ☐ Yes (type): _____

Exercise Frequency: ☐ None ☐ 1–2x/week ☐ 3–5x/week ☐ Daily

Dietary Preferences / Restrictions: _____

WOMEN'S HEALTH (Complete if applicable)

Date of Last Menstrual Period (LMP): _____

Are your periods: ☐ Regular ☐ Irregular ☐ post-menopausal ☐ Not applicable

Age at First Menstrual Period: _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure

If yes, how many weeks pregnant? _____

Number of Pregnancies: _____
Number of Live Births: _____
Number of Miscarriages: _____
Number of Abortions: _____

Method of Birth Control (if applicable): _____

Date of Last Pap Smear: _____

Result (if known): _____

Date of Last Mammogram (if applicable): _____

Result (if known): _____

History of:
☐ Abnormal Pap Smear
☐ Ovarian Cysts
☐ Endometriosis
☐ Polycystic Ovary Syndrome (PCOS)
☐ Fibroids
☐ Breast Disease or Breast Cancer
☐ Sexually Transmitted Infections

Please describe any gynecologic concerns or symptoms:

_____

_____

_____

_____

MEN'S HEALTH (Complete if applicable)

Do you currently have any concerns related to:
☐ Prostate health
☐ Urinary symptoms
☐ Erectile dysfunction
☐ Low libido
☐ Testicular pain or swelling

Date of Last Prostate Exam (if applicable): _____

Date of Last PSA Test (if known): _____

History of:
☐ Prostate enlargement
☐ Prostate cancer
☐ Testicular cancer
☐ Erectile dysfunction
☐ Sexually transmitted infections

Do you experience urinary symptoms such as:
☐ Difficulty starting urine
☐ Weak stream
☐ Frequent urination
☐ Nighttime urination

Please describe any men's health concerns or symptoms:

FINANCIAL POLICY & PATIENT RESPONSIBILITIES

Financial Responsibility & Physical / Insurance Coverage

I understand that I am responsible for all charges **not covered by my insurance**, including copayments, deductibles, non-covered services, and missed appointment fees. I may receive a statement for any unpaid balance.

Most insurance plans cover an **annual preventive physical exam**, but coverage **varies by plan**. Any services **beyond the preventive exam**, such as evaluation or treatment of chronic conditions, new symptoms, medications, or diagnostic testing, **may be billed separately**.

Medicare patients: Medicare does **not cover routine annual physicals**, but **does cover Annual Medicare Wellness Visits**, which focus on preventive care and health planning. Any evaluation or treatment outside these wellness visits may result in **separate charges** and patient responsibility.

I understand and agree to these term

STAFF

Alma Family Medicine is committed to providing a safe, respectful, and supportive environment for our patients, staff, and providers. We kindly ask that all patients and visitors treat our staff and other patients with **courtesy, respect, and professionalism** at all times. **Disrespectful, abusive, threatening, or bullying behavior**—including verbal abuse, harassment, discrimination, or inappropriate language—will **not be tolerated**

BROKEN APPOINTMENTS

All patients will be charged a broken appointment fee of $75.00 if they do not cancel their appointments 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.

CONSENT FOR TREATMENT I authorize the providers at Alma Family Medicine to evaluate, diagnose, and treat me as deemed medically appropriate.

Narcotic Prescriptions

All patients who are taking narcotics will be expected to have an office visit every 3 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

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SIGNATURE
Patient Signature: _____
Printed Name: _____
Date: _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS (FAX REQUEST)

PATIENT INFORMATION

Patient Full Legal Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

RECORDS TO BE RELEASED FROM (PREVIOUS PROVIDER)

Provider / Facility Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

RECORDS AUTHORIZED (CHECK ALL THAT APPLY)

☐ **Complete Medical Record**
☐ **Substance Abuse** ☐ **HIV related information**
☐ **Hospital Records / Discharge Summaries**
☐ **Mental Health Records (excluding psychotherapy notes unless specified)**

AUTHORIZATION & CONSENT

I authorize the above provider or facility to release the records indicated to Alma Family Medicine. I understand this authorization is voluntary and may be revoked in writing, except where action has already been taken. This authorization is valid for one (1) year from the date signed unless otherwise specified.

PATIENT SIGNATURE

Patient Signature: _____

Printed Name: _____

Date: _____

OFFICE USE ONLY

Patient ID: _____

Date Received: _____

Reviewed By: _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with HIPPA privacy standards.

Print name of patient:_____

Date of Birth:_____

My Authorization:

I authorize the following disclosing party:

Name:_____

Relationship to patient:_____

Contact information: _____

I, (print name of patient)_____authorize the above listed to receive and disclose information pertaining to me over the phone, via fax, e-mail, or mail. 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 it in person, via fax, e-mail, or mail to Alma Family Medicine.

This authorization expires: ___/___/_____

SIGNATURE

Patient Signature: _____

Printed Name: _____

Date: _____