



NEW PATIENT INFORMATION

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

By what name would you like to be addressed? \_\_\_\_\_ Age \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced

EMPLOYMENT \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ Retired \_\_\_\_\_ Self STUDENT \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse or Parent Name \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Reason for Visit

Referred by \_\_\_\_\_ Santa Fe Reporter \_\_\_\_\_ Pasatiempo \_\_\_\_\_ Phonebook \_\_\_\_\_ Internet

Referred by Doctor \_\_\_\_\_ Friend \_\_\_\_\_

MEDICAL INFORMATION

Medications you are allergic to \_\_\_\_\_  
\_\_\_\_\_

Medications you are taking \_\_\_\_\_  
\_\_\_\_\_

Air Travel can affect healing. Have you recently traveled or are you planning a trip? \_\_\_Y \_\_\_N

Do you take diet pills? \_\_\_Y \_\_\_N Name \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_Y \_\_\_N When \_\_\_\_\_

Last Physical Exam Date \_\_\_\_\_ Doctor \_\_\_\_\_

Results of Exam \_\_\_\_\_  
\_\_\_\_\_

Dates of: Last chest x-ray \_\_\_\_\_ EKG \_\_\_\_\_ Tetanus Shot \_\_\_\_\_

Are you currently having an evaluation for heart, lung, kidney or blood difficulties? \_\_\_Y \_\_\_N

- Have you ever had:
- \_\_\_ Rheumatic fever/heart disease
  - \_\_\_ Anemia
  - \_\_\_ Jaundice
  - \_\_\_ High blood pressure
  - \_\_\_ Nervous breakdown
  - \_\_\_ Frequent headaches
  - \_\_\_ Seizures

- Have any problems with:
- \_\_\_ Eyes
  - \_\_\_ Heart
  - \_\_\_ Lungs
  - \_\_\_ Stomach or bowels
  - \_\_\_ Urinary Tract
  - \_\_\_ Menstrual periods
  - \_\_\_ Abnormal bleeding

List any previous surgery \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any injuries, illness and hospitalization \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICAL INFORMATION (CONT.)

Do you take :	Never	Sometimes	Frequently	Daily	
Vitamins	_____	_____	_____	_____	Height _____
Sedatives	_____	_____	_____	_____	
Tranquilizers	_____	_____	_____	_____	
Sleeping pills	_____	_____	_____	_____	
Cortisone	_____	_____	_____	_____	Weight _____
Thyroid	_____	_____	_____	_____	
Aspirin	_____	_____	_____	_____	
Tylenol/Advil	_____	_____	_____	_____	

Do you use tobacco? \_\_\_ Y \_\_\_ N How much? \_\_\_\_\_

If you have ever used tobacco, when was the last time? \_\_\_\_\_

Do you use alcohol? \_\_\_ Y \_\_\_ N How much? \_\_\_\_\_

Do you use drugs? \_\_\_ Y \_\_\_ N How much? \_\_\_\_\_

Has any blood relative ever had diabetes, a nervous disorder, heart attack, cancer, high blood pressure, stroke or bleeding disorder? \_\_\_\_\_

Have there been any unexplained deaths or complications arising from anesthesia (including dental office) with any family members? \_\_\_\_\_

Is there a personal history of a muscle disorder (e.g. muscle weakness) ? \_\_\_\_\_

In case of an emergency notify \_\_\_\_\_ Phone \_\_\_\_\_

We appreciate having you as a patient. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Payment in full is expected at the time of service. We accept cash, checks, Visa or Mastercard. We will make every effort to work with you if a payment plan must be implemented. Delinquent accounts over 90 days will be turned over for collection if no attempt to communicate with this office has been made.

READ CAREFULLY AND SIGN THE FOLLOWING

I hereby authorize James Green, MD to furnish information to insurance carriers regarding my illness and treatments. I hereby assign to Dr. Green all payments for medical services rendered to myself or dependants. I understand that I am responsible for any amount not covered by my insurance. I am also responsible for contacting my insurance carrier after 30 days if they have not responded to the claims filed. I authorize Dr. Green to act as my agent with authority to contact insurance commissioner if necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_