SMG Specialty Care, SMG Women's and Family Health, SMG Primary Care, SMG Mancos Valley, SMG Walk-In Care, SMG School-Based Health Center, SMG Park Street

Please return or mail this packet to the New Patient Coordinator at 1311-A North Mildred Road, Cortez, CO 81321 in the medical office building on the Southwest Memorial Hospital Campus or fax it to (970) 564-2019. New Patient Coordinator phone number: (970) 516-1616.

NOTICE TO OUR PATIENTS

Thank you for choosing us as your healthcare provider. We look forward to providing an office environment and provider relationship that meets you and/or your family's medical needs.

Items to bring to your first appointment:

1. Driver's license or other photo identification.
2. All insurance cards.
3. Co-pays or payment in full at the time of your visit if you are not covered by insurance.
4. Actual bottles of all medications (prescribed and over the counter) that you are currently taking.

No-Show Policy

Our policy is to call patients the business day prior to their scheduled appointment to remind them of the appointment date and time. We perform these calls as a courtesy to our patients and to allow us the opportunity to reschedule the time slot should the appointment not be necessary. A phone call from you to cancel your appointment will allow us to schedule another patient that needs to be seen. Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide **24 hours notice** if you are unable to keep your appointment. This will allow us to call one of our patients on a waiting list to fill the available slot on the schedule.

To improve care for our patients, we will track all "No-Show" visits. Each patient will be allowed to miss two scheduled appointments within a **one year period** without penalty. Once a third appointment is missed, the patient will be at risk of being discharged from the practice or the Southwest Medical Group. To prevent this from happening, patients shall receive a letter each time they no-show for an appointment reminding them of our no-show policy.

For the purposes of this policy, a no-show appointment is defined as follows:

1. An appointment which is missed by the patient without any advance notice.
2. An appointment that is cancelled less than 24 hours prior to the scheduled appointment time.
3. An appointment in which the patient arrives 10 minutes or more beyond the scheduled appointment time.

Due to the check-in process, we request patients arrive 20 minutes prior to their scheduled appointment time to spend their allotted time with their provider.

Failure to show for the initial "new patient" appointment may eliminate your opportunity to establish care as a new patient.

Rx Refill Policy

Our policy is to refill patient prescriptions within 72 (business) hours of receiving the request. Please do not wait until you are completely out of medication or you will likely do without until the refill can be processed.

Patient Name:_____ Date of Birth:_____

Signed (signature required):_____ Date/Time:_____

Patient, Parent or Legal Guardian:_____ Date/Time:_____

SOUTHWEST MEDICAL GROUP
An Affiliate of Southwest Health System

SMG Specialty Care, SMG Women's and Family Health, SMG Primary Care, SMG Mancos Valley, SMG Walk-In Care, SMG School-Based Health Center, SMG Park Street

NEW PATIENT / HISTORY INFORMATION - ADULT

Date:_____

Patient Name: _____
First Name Middle Name Last Name

Date of Birth:_____ Age:_____ Gender:

Street Address:_____City/State/Zip:_____

Mailing Address (if different):_____City/State/Zip:_____

Best Contact Number:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address:_____

Would you like to sign up for our Southwest Medical Group patient portal? ☐ No ☐ Yes

Social Security #_____-_____-_____Primary Care Physician:_____

Language:_____Race:

Marital Status: Number of Children_____

Occupation:_____ Retired?

Patient's Employer:_____

Business Address:_____Phone: _____

Name of Primary Insurance:_____Name of Primary Insurance Holder:_____

Member ID#:_____Group #:_____

Name of Secondary Insurance:_____

Member ID#:_____Group#:_____

Patient's Relationship to Insurance Holder:_____

In case of Emergency, who should be notified? Name:_____

Relationship to Patient:_____Contact Phone Number:_____

SOUTHWEST MEDICAL GROUP
An Affiliate of Southwest Health System

Patient Name:_____ Date of Birth: _____
First Name Middle Name Last Name

Please list providers whom you have received care from in the past:

Primary Doctors: _____

Other Doctors: _____

Current Medications:

(*include all over-the-counter drugs or products such as, aspirin, nose sprays, herbs, vitamins, etc.)*

Name of Drug	Dose	Times Per Day

Preferred Pharmacy:_____ **Address (City):**_____

Allergies: *(include medications, pollens, foods, and animals)*

Drug / Type	Reaction

Past Medical History (*Please circle Yes or No to indicate if you have ever had the following)*

Disease or Condition	Y	N	Duration
Alcoholism	Yes	No	
Anemia / Blood Disorders	Yes	No	
Arthritis / Gout	Yes	No	
Asthma or other Respiratory Problems	Yes	No	
Cancer **Type:**	Yes	No	
Diabetes	Yes	No	
Drug Addictions **Type:**	Yes	No	
Eye Disease	Yes	No	
Frequent or Serious Infections	Yes	No	
Heart Disease / Attack	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Hormone Problems	Yes	No	
Kidney Disease / Stones	Yes	No	
Liver Disease / Hepatitis **Type:**	Yes	No	
Lung Disease / COPD	Yes	No	
Mental Health Problems or Depression	Yes	No	
Muscle Weakness	Yes	No	
Nerve Disorders / Migraines / Seizures	Yes	No	
Reflux / Heartburn / GERD/ Ulcers	Yes	No	
Rheumatic Fever	Yes	No	
Serious Injuries or Fractures	Yes	No	
Skin Disease	Yes	No	
STD / Genital Problems	Yes	No	
Stroke	Yes	No	
Thyroid Problems	Yes	No	
Tuberculosis	Yes	No	
Urinary Disorders/Prostate problems/ Incontinence	Yes	No	

Have you ever had a history of blood clots in legs or lungs (pulmonary embolus)? ☐ No ☐ Yes

Other Medical Problems Not Mentioned Above

Disease or Condition	Duration / Year

Past Surgical History: *(include ALL surgeries and left or right side if applicable)*

If you have ever had surgery, please list the types and approximate date(s):

Year	Operation	Anesthesia	Any Complications with Surgery or Anesthesia?

Have you ever received a blood transfusion? ☐ No ☐ Yes If yes, what year_____

Have you ever been hospitalized for any illness? ☐ No ☐ Yes

If yes, for what illness and year of hospitalization(s)?_____

Please list any street drugs currently used: ☐ Marijuana ☐ Other(s): _____

Prior Tests / Exams History

Prior Tests / Exams	Y	N	Year	Normal / Abnormal
Bone Density (after 65)	Yes	No		
Colonoscopy (after 50)	Yes	No		
Lipids/Cholesterol (after 45)	Yes	No		
Mammogram (after 40)	Yes	No		
Pap Smear/Pelvic	Yes	No		
Stress Test	Yes	No		
Thyroid Function Test	Yes	No		
HIV Test	Yes	No		
Last Dental Exam	Yes	No		
Last Vision Exam	Yes	No		

Diabetic History

Fasting Blood Sugar: _____ Last A1C Date:_____ Percentage: _____

Immunization History (please list date of last immunization or test)

Chicken Pox Vaccine Date:_____
Flu Vaccine Date:_____
Hepatitis Vaccine Date:_____
Pneumonia Vaccine Date:_____
Polio Vaccine Date:_____
Rubella or MMR Vaccine Date:_____
Shingles Vaccine Date:_____
Tetanus Vaccine Date:_____
TB Skin Test Date:_____
HPV Vaccine Date(s):_____
(ages 9-26; ideally ages 9-12 both females and males)

Family History

Are you adopted? ☐ No ☐ Yes

Relation	Living?	Age	Age at Death (if deceased)	Cause of Death
Father				
Mother				
# Brother(s): _____	# living:			
# Sister(s): _____	# living:			

SOUTHWEST MEDICAL GROUP
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Please indicate who (if any) of YOUR IMMEDIATE BLOOD RELATIVES have had any of the following:
[Please list which relative(s) and the type of disease or condition if applicable, (ex.- grandmother, mother's side, lung cancer)]

Disease or Condition	Relationship to You	Type *(if applicable)**
Alcohol or Drug Dependency		*
Arthritis / Gout		*
Asthma / Hay Fever		
Breast Cancer		
Colon Cancer		
Diabetes		*
Heart Disease / Attack		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Lung Disease / COPD		
Mental Health Problems or Depression		*
Migraines / Seizures		
Multiple Sclerosis		
Obesity / Weight Disorder		*
Osteoporosis		
Other Cancer		*
Ovarian Cancer		
Parkinson's		
Stroke		
Thyroid Disorders		
Tuberculosis		
Uterine Cancer		

For Females:

Pregnancies

Year	Delivery Type	Any Complications?
	☐Vaginal ☐ C-Section	
	☐Vaginal ☐ C-Section	
	☐Vaginal ☐ C-Section	
	☐Vaginal ☐ C-Section	

Abortions: ☐ No ☐ Yes #_____ Miscarriages: ☐ No ☐ Yes #_____

Last menstrual period:_____ Birth Control : ☐ No ☐ Yes Type: _____

Menopause: ☐ No ☐ Yes Age:_____ Hysterectomy: ☐ No ☐ Yes

SOUTHWEST MEDICAL GROUP
An Affiliate of Southwest Health System

Social History

Born in: _____ Raised in: _____ Living in:_____ For how long?:_____

Religion: _____

Highest Education Level Achieved: ☐ Elementary ☐ Jr. High ☐ High School ☐ College ☐ Post-Graduate

Do you feel safe in your home? ☐ No ☐ Yes Have you ever been abused (physical/sexual)? ☐ No ☐ Yes

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Do you have Advanced Directives? ☐ No ☐ Yes Living Will? ☐ No ☐ Yes

If yes, is the documentation on file at a Southwest Medical Group clinic or your Primary Care Provider? ☐ No ☐ Yes

Risk Factors

Do you or have you used tobacco products? ☐ Yes, current ☐ Yes, former ☐ Never

If yes, what type? (cigarettes, chew, pipe, etc.)_____

If a cigarette smoker: _____pack(s) Age started?_____ If former, year you quit?_____

If current smoker, would you like help in quitting? ☐ No ☐ Yes

Is there tobacco use by others in the home? ☐ No ☐ Yes

If yes, what type? (cigarettes, chew, pipe, etc.)_____

Do you use recreational drugs? ☐ No ☐ Yes ☐ Rarely If yes, what kind?_____

Do you drink alcohol? ☐ No ☐ Yes ☐ Rarely If yes, what kind?_____

If yes,_____drinks/day,_____ drinks/week,_____drinks/month

Do you drink caffeinated beverages? ☐ No ☐ Yes ☐ Rarely

If yes, what kind?_____If yes,_____drinks/day

Do you exercise regularly? ☐ No ☐ Yes If yes, what activities?_____Days/Week_____

Do you wear a seat belt? ☐ No ☐ Yes If you have children, do they wear a seat belt? ☐ No ☐ Yes

SOUTHWEST MEDICAL GROUP
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:	Phone Number: _____
Address:	Date of Birth: _____
	Last 4 digits SSN#: _____ (optional)

I, _____, hereby authorize disclosure of my protected health information as follows:

RELEASE FROM:

Facility, Person, Provider:	Phone Number: _____
Address:	Fax Number: _____*
	E-mail: _____ (e-mailed information will be encrypted)

RELEASE TO:

Facility, Person, Provider: Southwest Medical Group	Phone Number: 970-565-8556
Address: 1311-A N. Mildred Rd., Cortez, CO 81321	Fax Number: 970-564-1134*
	E-mail: _____ (e-mailed information will be encrypted)

***SHS DOES NOT FAX PERSONAL HEALTH INFORMATION TO HOME FAX MACHINES**

Information to be released: From (date) _____ to (date) _____

- ☐ Treatment Records-Hospital
- ☐ Office Visit Notes - Clinic
- ☐ Consultation Reports
- ☐ Other, list below:
- ☐ Laboratory Reports
- ☐ Diagnostic Imaging Reports
- ☐ Operative Reports
- ☐ Emergency Room Records
- ☐ Discharge Summary
- ☐ Ambulance Run Reports
- ☐ History and Physical
- ☐ Pathology Reports
- ☐ Sleep Lab Reports

_____.

Purpose of Release: ☐ Medical Care ☐ Transferring Care ☐ Attorney ☐ Personal Records ☐ Other: _____.

Sensitive Information: I understand by checking any boxes below, I have given permission to release confidential information related to HIV, Mental Health Care, or Drug and Alcohol Treatment, which is protected by federal law 42 CFR Part 2. (If the boxes are not checked, this information will **NOT** be released.)

- ☐ Diagnosis and/or treatment relating to drug or alcohol abuse
- ☐ Diagnosis and/or treatment relating to mental health conditions
- ☐ Diagnosis and/or treatment relating to HIV testing, infection or diagnosis and/or treatment for AIDS

Right to Revoke: I understand that I may revoke this Authorization at any time by notifying Southwest Health System, Inc., in writing. I understand that revocation will not have any effect on actions taken prior to receipt of the revocation.

Expiration: This Authorization will automatically expire 180 days from the date of my signature, unless otherwise specified as follows: _____(date).

Re-Disclosure: I understand that the information used and/or disclosed according to this Authorization may no longer be protected by federal privacy law also known as HIPAA, and the recipient of the health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

With my signature below, I acknowledge and authorize Southwest Health System, Inc., to use and/or disclose my protected health information as described above. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.

Patient name printed: _____ Date of Signature: _____/Time:_____

Patient signature: _____

Patient representative name printed: _____

Patient representative signature: _____/ Relationship to Patient: _____

SOUTHWEST HEALTH SYSTEM

PATIENT DISCLOSURE AUTHORIZATION

Location: Southwest Medical Group Primary Care	Today's Date:
Name of Patient	DOB:
Patient Contact Number:	

I, _____, do hereby authorize disclosure of my protected health information to the specific individual(s) described below:

Individual(s) authorized to receive HIPAA protected information:

1. _____/_____
   Name Relationship

2. _____/_____
   Name Relationship

The individual listed above may have access to the information checked below:

☐ Medical information from my provider

☐ May pick up written prescriptions for me

☐ May receive phone messages for me, phone number: _____

☐ May receive lab/pathology results, diagnostic imaging results, results of procedures

I may revoke this Authorization at any time, provided that the revocation is in writing.

I have read this form or have had it read to me, and I fully understand the contents.

I have received a copy of this completed Authorization and can request a copy at any time.

_____ _____
Signature of Patient Date/Time

_____
Signature of Legal Representative, Parent, Guardian