



Affiliated Clinics: SMG Primary Care, SMG Women's and Family Health, SMG Specialty Care, SMG Mancos Valley, SMG Pulmonary and Sleep, Southwest Walk-In Care, Southwest School-Based Health Center

## **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.

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.

Signed (signature required):

Patient, Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**SOUTHWEST  
MEDICAL GROUP**

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**NEW PATIENT / HISTORY INFORMATION**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

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: [American Indian or Alaska Native/ Native American / African American / Asian / Chinese / Filipino / Japanese / White / Hispanic / Native Hawaiian / Other]

Marital Status: [Single Married Separated Divorced Widowed] Number of Children \_\_\_\_\_

Occupation: \_\_\_\_\_ Retired? Y / N \_\_\_\_\_

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: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referred By:  Self  Friend  Dr. \_\_\_\_\_  Other: \_\_\_\_\_

OB provider preference: \_\_\_\_\_

### **CURRENT MEDICATIONS AND ALLERGIES**

If you are currently taking any medication(s), or have taken any since you have been pregnant (include any Over the Counter Medications), please complete the information about these drugs below:

Name of Medication	Date Started/Recent Dose	Reason for Taking	Prescribing Doctor's Name

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Please list any known allergies and what type of reactions:

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### **OB INITIAL INTAKE**

Positive Urine Pregnancy Test by:  self  other: \_\_\_\_\_ Occupation: \_\_\_\_\_

Type of work: \_\_\_\_\_ Education (highest level completed): \_\_\_\_\_

If you do heavy labor or exercise, please describe: \_\_\_\_\_

Number of children at home: \_\_\_\_\_

Please list people living in household with you:

Name	Age	Relation to You

Planned Hospital of Delivery (if other than Southwest Memorial): \_\_\_\_\_

Planned Newborn's Provider (if other than your Southwest Medical Group provider): \_\_\_\_\_

### **FATHER OF BABY (FOB)**

Will the father of the baby be involved?

If yes, name of husband/father of baby: \_\_\_\_\_ FOB Occupation: \_\_\_\_\_

FOB Phone Number: \_\_\_\_\_ FOB Highest level of Education: \_\_\_\_\_



Was this pregnancy unplanned?  Yes  No

Are you or the baby's father unhappy about this pregnancy?  Yes  No If yes, who: \_\_\_\_\_

Have you ever tried, but could not get pregnant for over 1 year?  Yes  No

### **MENSTRUAL HISTORY**

Date **LAST** menstrual period (LMP) began: \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_\_

LMP character:  Light  Normal  Heavy

How certain are you of the month?  Very certain  Unsure Of the date?  Very certain  Unsure

Do you know the date of conception?  Yes  No If yes, what date? \_\_\_\_\_ / \_\_\_\_\_ / 20\_\_\_\_

Menarche (age when periods began): \_\_\_\_\_

Menses Interval (how many days between periods): \_\_\_\_\_ Days

Approximate length of menstrual flow: \_\_\_\_\_ Days

Were you on Birth Control Pills at conception?  Yes  No If yes, date you took last pill: \_\_\_\_\_

If you used another method of birth control just before or since your LMP, what was it? \_\_\_\_\_

Date of Home Pregnancy Test: \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_\_

Pre-Pregnancy Weight: \_\_\_\_\_ lbs.

**Symptoms since LMP:**  amenorrhea (no menses)  nausea  vomiting  fatigue  irritability  bloating  
 tender breasts  urinary frequency  other: \_\_\_\_\_

Have you experienced any of the following since your LMP?

Pain:  Yes  No If yes, please explain: \_\_\_\_\_

Bleeding:  Yes  No Spotting:  Yes  No Discharge:  Yes  No

Any other medical problem or accidents since your LMP? \_\_\_\_\_

### **PAST MEDICAL HISTORY**

Did you have diabetes, high blood pressure, bleeding, depression or any other medical problem during a previous pregnancy?  Yes  No If yes, list the problems: \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, what type: \_\_\_\_\_

Do you have any abnormality of female organs (uterus/cervix)?  Yes  No

If yes, please explain: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_\_

Have you ever had an abnormal pap smear?  Yes  No

If yes, what type of treatment if any did you have to cervix or uterus? \_\_\_\_\_

Please indicate if you, the father of the baby, or any of your family members have a history of the following:

Disease/Condition	Yourself	Baby's Father	Family Members
Asthma/Lung Problems/Tuberculosis			
Cancer (What type?)			
Convulsions (Epilepsy)			
Diabetes			



Drinking problems			
Heart trouble below age 50			
High Blood Pressure			
Kidney Disease			
Thyroid trouble			
Trouble with Nerves/Depression			

### **SOCIAL HISTORY/RISK FACTORS**

What is your religious preference? \_\_\_\_\_ FOB's religious preference? \_\_\_\_\_

Do you smoke cigarettes?  Yes  No If yes, how much? \_\_\_\_\_ For how many years? \_\_\_\_\_

Do you use any other tobacco products?  Yes  No If yes, what type? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, what type of drinks? \_\_\_\_\_ How much in one week? \_\_\_\_\_

Have you or any of your sexual partners ever used any street drugs?  Yes  No If yes, who? \_\_\_\_\_

If yes, did either of you ever inject (shoot up) any drugs?  Yes  No If yes, type? \_\_\_\_\_

Within the past year, have you been threatened or physically hurt by someone in any way?

Yes  No Since being pregnant?  Yes  No If yes, please explain:

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Have you been forced to perform any sexual act that you did not want to do?  Yes  No If yes, please explain:

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### **PAST PREGNANCY HISTORY**

Please list details for all of your previous pregnancies below. If this is your FIRST pregnancy, please skip to Genetic History section.

Child's Name	Date of Birth	Birth Weight	Sex	Type of Delivery	Location	Complications
		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		
		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		
		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		
		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		
		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		
		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		



		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		
		lbs. oz.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section		

Did you experience early labor or were any babies premature or overdue?  Yes  No

If yes, how many weeks? \_\_\_\_\_

Did you ever lose a pregnancy (by abortion, miscarriage, stillbirth, or ectopic (tubal) pregnancy?  Yes  No

If yes, dates and type: \_\_\_\_\_

Did you ever lose a child that was born alive?  Yes  No

Were any of your babies born breech?  Yes  No

Were any of your babies born with birth defects or deformities?  Yes  No If yes, list: \_\_\_\_\_

Did any of your babies develop jaundice, infection, or any other problems during the first two weeks of life?

Yes  No If yes, please explain: \_\_\_\_\_

## GENETIC HISTORY

Will you be 35 years or older at the time the baby is born?  Yes  No

Please indicate if you, the baby's father, or any family members have or have experienced any of the following:

Disease/Condition	Yourself	Baby's Father	Family Members
Thalassemia (blood disorder)			
Neural Tube Defect			
Down's Syndrome			
Tay-Sachs (rare nerve disorder)			
Sickle Cell Disease/Trait			
Hemophilia			
Muscular Dystrophy			
Cystic Fibrosis			
Huntington's Disease			
Mental Retardation			
Fragile X			
Other Genetic/Chromosomal			
Other Birth Defects/Inherited Diseases (cleft lip, clubfoot, or any others)			



Hearing loss in infancy			
More than 3 miscarriages			
History of Stillbirth			
Multiple Births (twins, triplets, etc.)			
Come from the Philippines, Mediterranean Area, or S.E. Asia			
Lived in Africa or Haiti			

### INFECTION HISTORY

Are you at risk for Hepatitis B (multiple partners, IV Drug use, partners with Aids, etc)?  Yes  No

Have you been immunized against Hepatitis B?  Yes  No

Have you ever been exposed to TB?  Yes  No

Do you have a history of Genital Herpes?  Yes  No

Have you had a sexual partner with Genital Herpes?  Yes  No

Have you ever had a STD (Gonorrhea, Chlamydia, Syphilis, HPV)?  Yes  No If yes, type: \_\_\_\_\_

Since your LMP, have you had a fever, rash or viral illness?  Yes  No If yes, type: \_\_\_\_\_

Are you exposed to cat litter?  Yes  No

Have you had the chicken pox?  Yes  No Or the vaccine?  Yes  No

Have you ever had Parvovirus (Fifth Disease)?  Yes  No

Do you have occupational exposure to children?  Yes  No

If yes, which?  Daycare  Teacher  Other: \_\_\_\_\_

### ENVIRONMENTAL EXPOSURES

Are you exposed to X-rays?  Yes  No

Are you exposed to chemicals or other hazardous materials?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## CONSENT FOR OB PATIENT DRUG AND/OR ALCOHOL TESTING

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Thank you for choosing us to provide your maternity care. In order to help you and your physician make better decisions regarding your prenatal treatment, it is our policy to perform drug and/or alcohol screening for all initial obstetrics visits. Additional or repeat screening may be performed as deemed necessary by your physician for the duration of your maternity care with our office.

By my signature below, I acknowledge that I have read and understood the information in this consent. Further, I acknowledge that I have given consent for the performance of drug and/or alcohol testing as deemed necessary by my physician or his/her designee. Testing will be performed by employees of Southwest Health System, Inc. Results of testing will be released as needed for appropriate medical treatment.

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

If signed by other than patient, indicate relationship to patient: \_\_\_\_\_

**This consent may be signed by a person other than the patient, only under the following circumstances:**

1. The patient is under 12 years of age or, as a result of his/her physical condition, is unable to provide consent.
2. The person who consents to the testing on the patient's behalf is lawfully authorized to make healthcare decisions for the patient.
3. It is necessary to obtain the patient's test results in order to render appropriate care to the patient or to practice prevention measures per Health and Safety Codes section 119.27



### Cystic Fibrosis/Spinal Muscular Atrophy/Fragile X Carrier Testing

As of March 2017, the American College of Obstetrics and Gynecology recommends that carrier screening for both Cystic Fibrosis and Spinal Muscular Atrophy be made available for all patients who are pregnant or considering pregnancy. We also offer genetic carrier testing for Fragile X Syndrome.

Cystic Fibrosis (CF) is characterized by the buildup of thick, sticky mucus that can damage many of the body's organs. The disorders most common signs and symptoms include progressive damage to the respiratory system and chronic digestive system problems. The features of the disorder, and their severity, varies among affected individuals. CF does not affect a person's learning ability or his/her appearance. More than 25,000 American children and young adults have CF; about 850 cases of CF are diagnosed each year.

Spinal Muscular Atrophy (AMA) is a disorder that affects the control of muscle movement. It is caused by a loss of specialized nerve cells, called motor neurons, in the spinal cord and the brainstem. The loss of motor neurons leads to weakness and atrophy of muscles used for activities such as crawling, walking, sitting up and controlling head movement. In severe cases of SMA, the muscles used for breathing and swallowing are affected. There are many types of spinal muscular atrophy distinguished by the pattern of features, severity of muscle weakness, and age when the muscle problems begin.

Most people have two normal copies of these genes. Carriers have one normal and one abnormal gene. CF and AMA are autosomal recessive conditions (meaning you get one abnormal gene from each parent) found more commonly in individuals of Caucasian decent. When both parents are carriers (one normal and one abnormal copy of the gene) there is a 25% chance to have an affected child with each pregnancy. An affected child has two abnormal copies of the gene. If both parents are documented carriers, prenatal diagnosis is available via more invasive specialized testing (amniocentesis or CVS).

Fragile X Syndrome is a genetic disorder with symptoms of mild to moderate intellectual disability and unusual physical features such as large ears, narrow long face and flexible fingers. It is typically more severe in males compared to females and is twice as common in males (1-3600 males). There are often features of autism and seizures as well. This disorder is due to genetic mutations of the X gene.

Cost and insurance coverage for genetic carrier testing depends upon your insurance policy. Insurance companies may or may not cover the cost of testing. If you choose to have the testing and it is not covered by your insurance company, you would be responsible for the cost.

My provider has reviewed the above with me and answered my questions.

No, I am not interested in CF/SMA/Fragile X Carrier testing.

Yes, I would like to have CF/SMA/Fragile X Carrier testing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### 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:	Phone Number: _____
Address:	Fax Number: _____ *
	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) \_\_\_\_\_

<input type="checkbox"/> Treatment Records-Hospital	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Office Visit Notes - Clinic	<input type="checkbox"/> Diagnostic Imaging Reports	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Ambulance Run Reports	<input type="checkbox"/> Sleep Lab Reports
<input type="checkbox"/> Other, list below: _____			

**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: \_\_\_\_\_