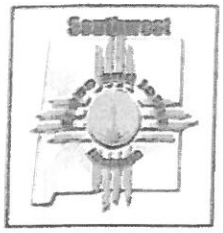

Southwest Bone and Joint Institute
1268 E. 32nd Street
Silver City, NM 88061
Office (575) 534-1919 Fax (575) 534-0135

Patient Information Record

Today's Date: _____

Patient Name: _____

Mailing Address: _____

Physical Address: _____

Social Security Number: _____-_____-_____

Birthdate: _____/_____/_____ **Gender:** ☐ Male ☐ Female

Home Phone Number: _____

Work Phone Number: _____ **Cell Phone Number:** _____

Patient Email: _____ **PCP:** _____

Emergency Contact Person: _____

Relationship: _____ **Emergency Phone Number:** _____

Marital Status: Married ☐ Single ☐ Other ☐

Primary Insurance Name: _____

Policy Number: _____

Group Number: _____

Secondary Coverage

Secondary Insurance Name: _____

Secondary Insurance Policy Number: _____

Group Number: _____

Insured Name: _____

PLEASE PRESENT YOUR INSURANCE CARD AND A PICTURE ID AT THE FRONT DESK

Race: American Indian ☐ Black or African American ☐ White ☐ Other Race ☐
Preferred Language: English ☐ Spanish ☐ Other ☐
Ethnicity: Black ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐

Local Pharmacy: _____

Employer: _____

Employer Address: _____
_____

Employer Phone: _____ **Email:** _____

SPOUSE INFORMATION

Name: _____ **SSN:** ___-___-___ **DOB:** _____

Employer: _____ **Work Phone:** _____

GUARDIAN/PARENT INFORMATION IF PATIENT IS A MINOR

MOTHER
Name: _____ **DOB:** _____
SSN: ___-___-_____
Employer: _____
Address: (If Different from Above) _____

FATHER
Name: _____ **DOB:** _____
SSN: ___-___-_____
Employer: _____

Home Phone: _____ **Work Phone:** _____

CHECK-OUT NOTE

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient relations dept. prior to SURGERIES. I understand that if I miss two consecutive therapy appointments, I may be removed from the therapy schedule.

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION

I herby authorize release of any medical information necessary to process my insurance claims. Furthermore, I irrevocably ASSIGN to SOUTHWEST BONE AND JOINT INST. and/or it's DOCTORS any and all payments from my insurance(s) for services rendered. I understand and agree to the above conditions. This authorization can only be revoked in writing. A copy of the authorization shall be as valid as the original.

FINANCIAL RESPONSIBLE PARTY

I/we, _____,(Patient/Parent/Guardian) agree to be financially responsible for any and all medical bills and/or costs not paid by insurance, Medicare and/or Medicaid for _____(patient). I shall immediately inform and provide the necessary information to Southwest Bone and Joint Institute, P.C. of any and all changes in my insurance, Medicare and/or Medicaid policies. I understand this is a Contract and I agree that if Southwest Bone and Joint Institute, P.C. has to proceed with collections of monies owed on this account, then I/we will be liable for Southwest Bone and Joint Institute, P.C. attorney's fees and costs.

Signature: _____ **Date:** _____

Health History

Please complete the following information for review by your provider

Name: _____ **Birth Date:** ___/___/___ **Age:** _____

Sex: ☐ M ☐ F **Family Doctor:** _____ **Occupation:** _____

Patient Medical History

☐ Heart Trouble	☐ High Blood Pressure	☐ Stroke	☐ Diabetes	☐ Arthritis
☐ Kidney Trouble	☐ Osteoporosis	☐ Bleeding Problems	☐ Lung Disease	☐ Asthma
☐ Blood Clots	☐ Anemia	☐ Stomach Ulcers	☐ Liver Trouble	☐ Cancer
☐ MRSA	☐ AIDS/HIV	☐ Hepatitis	☐ Other _____	

Previous Surgeries: ☐ None

Previous Surgeries	Hospital/Date	Previous Surgeries	Hospital/Date
1.		4.	
2.		5.	
3.		6.	

Problems with anesthesia: ☐ Yes ☐ No
If Yes, Describe: _____

Allergies to Medications: ☐ None ☐ Yes, List →

Medication	Allergic Reaction

Medications you currently take (including over the counter medications, vitamins, herbs & prescribed drugs):
☐ **See separate medication list** ☐ **Not taking any medications as of** _____ **(date)**

Date	Medication	Dosage/Frequency	Why are you taking this medication?

Patient Signature: _____ Date: _____

Southwest Bone and Joint Institute
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Office (575)-534-1919 Fax (575)534-0135

NOTICE OF PRIVACY PRACTICES

Privacy Officer – Mike McMillan
575-534-1919

EFFECTIVE DATE: JUNE 01, 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

THIS IS AN OUTLINE OF OUR NOTICE OF PRIVACY PRACTICE

A. How This Medical Practice May Use or Disclose Your Health Information

B. When This Medical Practice May Not Use or Disclose Your Health Information

C. Your Health Information Rights

1. Right to Request Special Privacy Protections
2. Right to Request Confidential Communications
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper Copy of this Notice

D. Changes to this Notice of Privacy Practices

E. Complaints

PLEASE FIND COMPLETE NOTICE OF PRIVACY PRACTICE AT:

http://southwestboneandjoint.com/page28/page28.html

OR REQUEST A PRINTED COPY

Please Initial: **Prefer Copy_____** **Decline Copy_____**

PATIENT COPY

Southwest Bone and Joint Institute
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Office (575)-534-1919 Fax (575)534-0135

ACKNOWLEDGEMENT

In accordance with HIPAA guidelines, Southwest Bone & Joint Institute is providing you with access/copy of the Notice of Privacy Practices.

I authorize the medical practice to download and view my prescription history via the Surescripts database. I understand that my prescription history from other healthcare providers, insurance companies, and third party pharmacy benefit managers may be viewable by our providers and staff.

I, the undersigned, acknowledge that I have received access/copy of The Notice of Privacy Practices.

Signed _____ Date _____

Please Initial: Prefer Copy_____ Decline Copy_____

Printed Name _____

If signing off as a parent or guardian, name of patient: _____

Office Copy