Acknowledgement of Privacy Statement, Authorization and Assignments of Benefits

Patients Name (Please print) _____Date of Birth _____

Guarantor's Name (Please print) _____Date of Birth _____
(If patient is a minor or dependent)

Privacy Statement

I acknowledge that I have been informed of the Notice of Privacy Practices and the notice is available to me. Upon my request, I will receive a copy of the Notice of Privacy Practices, September 23, 2013 version. I understand that it is my responsibility to read the information provided therein.

Signature: _____Date:_____
(If patient is a minor dependent, parent or legal guardian must sign)

Release of Medical Information, Appointments and Prescriptions

If patient is a minor or dependent, all parents or legal guardians must be listed below.

Should it become necessary, New Mexico Clinical Research & Osteoporosis Center, Inc. physicians and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorized for the above statement regarding appointments and prescriptions. I understand that if I need to change this information, it is my responsibility to request this in writing.

Name:_____Relationship:_____

Phone No._____ ( ) Home ( ) Work ( ) Cell

Name:_____Relationship:_____

Phone No._____ ( ) Home ( ) Work ( ) Cell

Signature:_____Date:_____
(If patient is a minor or dependent, parent or legal guardian must sign)

Financial and Credit Policy

I acknowledge that I have been informed of the Financial and Credit Policy and the policy is available to me upon my request. The policy provides me with information pertaining to co-pays, coinsurance, deductibles, and the statement process for any outstanding balances due on my account. The policy also addresses my responsibility to provide 24-hours notice if I am unable to keep my appointment and the requirement by my insurance company to obtain and provide a doctor's order from my primary care provider for bone density testing. I understand that it is my responsibility to read the information provided therein.

Signature: _____Date:_____
(If patient is a minor dependent, parent or legal guardian must sign)

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by New Mexico Clinical Research & Osteoporosis Center, Inc. (NMCROC). I request payment of authorized Medicare, Medigap or other health insurance policy benefits for services rendered to me by NMCROC be made on my behalf to NMCROC. I request that payment of government benefits, if applicable, to the party who accepts assignment. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered. I understand that I have the right to revoke this agreement in writing.

Signature: _____Date:_____
(If patient is a minor or dependent, parent or legal guardian must sign)

MEDICAL HISTORY FORM – PAGE 1

NAME_____AGE ____TODAY'S DATE _ _____

OCCUPATION _ _____SEX _____

WHO REFERRED YOU? _____ _____

FAMILY HISTORY (List any blood relatives with the following problems)

ASTHMA _____HEART DISEASE_____

BLEEDING DISORDER _____HIGH BLOOD PRESSURE _ _____

CANCER _____ STROKE __ _____

DIABETES _____ THYROID DISEASE-_____

OSTEOPOROSIS _____OTHER_____

MEDICATIONS, VITAMINS, MINERALS, SUPPLEMENTS, HERBS (List name and dose)

_____

_____

_____

ALLERGY TO MEDICATIONS (Name of medicine and type of reaction)

_____

_____

OPERATIONS (Name and date)

_____

_____

_____

HABITS

SMOKING (PACKS/DAY) _____

ALCOHOL (DRINKS/DAY) _____

IMMUNIZATIONS AND TESTS (Give date you have most recently had each of these)

TETANUS SHOT _____	PAP SMEAR _____	COLONOSCOPY _____
FLU SHOT _____	MAMMOGRAM _____	STOOL BLOOD TEST _____
PNEUMOVAX _____	ZOSTAVAX _____	BONE DENSITY TEST _____

-PLEASE CONTINUE ON NEXT PAGE –

MEDICAL HISTORY FORM- PAGE 2

PLEASE CHECK TO INDICATE ANY *RECENT* SYMPTOMS

GENERAL
- O FALLING IN PAST YEAR
- O AIDS RISK FACTORS
- O DEPRESSED
- O FEVER
- O LOSS OF APPETITE
- O NERVOUS
- O TIRED
- O TROUBLE SLEEPING
- O WEIGHT GAIN
- O WEIGHT LOSS

EYES
- O RED EYE
- O VISUAL PROBLEMS

ENT
- O DIZZINESS
- O HAY FEVER
- O HEADACHES
- O HEARING PROBLEMS
- O DENTAL PROBLEMS

ENDOCRINE
- O DIABETES
- O THYROID DISEASE

RESPIRATORY
- O ASTHMA
- O COUGHING
- O COUGHING BLOOD
- O SHORT OF BREATH

CARDIOVASCULAR
- O CHEST DISCOMFORT
- O CHEST PAIN
- O HEART ATTACK
- O HEART MURMUR
- O HEART SKIPPING
- O HIGH BLOOD PRESSURE
- O HIGH CHOLESTEROL
- O PALPITATIONS
- O SWOLLEN ANKLES

GASTROINTESTINAL
- O ABDOMINAL PAIN
- O BLACK STOOL
- O BLOOD IN STOOL
- O CHANGE IN STOOLS
- O CONSTIPATION
- O DIARRHEA
- O GALL STONES
- O HEARTBURN
- O HEMORRHOIDS
- O HEPATITIS
- O INDIGESTION
- O JAUNDICE
- O NAUSEA
- O TROUBLE SWALLOWING
- O ULCER
- O VOMITING
- O VOMITING BLOOD

UROLOGICAL
- O BLADDER INFECTIONS
- O BLOOD IN URINE
- O BURNING ON URINATION
- O FREQUENT URINATION
- O KIDNEY INFECTIONS
- O KIDNEY STONE

NEUROLOGICAL
- O CONFUSION
- O FAINTING
- O NUMBNESS
- O PARALYSIS
- O POOR MEMORY
- O SEIZURES
- O STROKE
- O TINGLING
- O WEAKNESS

SKIN
- O RASH
- O ITCHING

HEMATOLOGICAL
- O ANEMIA
- O BLEEDING PROBLEM
- O BLOOD CLOTS

MUSCULO-SKELETAL
- O ARTHRITIS
- O BACKPAIN
- O GOUT
- O SWOLLEN JOINTS

OSTEOPOROSIS
- O LOW BONE DENSITY
- O OSTEOPOROSIS
- O BROKEN BONE

MALE ONLY
- O IMPOTENCE
- O PAINFUL TESTICLE
- O PENILE DISCHARGE
- O PROSTATE PROBLEMS
- O SWOLLEN TESTICLE
- O WEAK STREAM

FEMALE ONLY
- O BREAST LUMP
- O HOT FLASHES
- O MENSTRUALPROBLEMS
- O PELVIC PAIN
- O VAGINAL DISCHARGE

ANY OTHER PROBLEMS?

_____

_____

_____

_____

_____

Office Use Only- Revised 01/11

History Reviewed With Patient