999 W. Amador Ave., Las Cruces, NM 88005 (575) 527-5482 Voice 575-652-4243 Fax

Patient Information

Last Name________________________First Name______________________Middle______________________

Preferred First Name:____________________________________

Social Security #____Date of Birth _________________________

Address____City____________________________

State________________________Zip Code____________________Phone (   ) _______________________

Work Phone (   )___________________ **Email address** ____

Emergency Contact & Relationship (   )____

Race: *(circle all that apply)* White African American Native American Other:____________ Decline to Answer

Ethnicity: *(Circle One)* Hispanic Non-Hispanic Decline to Answer

Homeless status: *(Circle One)* Doubling up Not Homeless Shelter Street Transitional

Migrant Worker: *(Circle One)* Migrant Not a Farm Worker Seasonal

Preferred Spoken/ Written Language: *(Circle One)* English Spanish Other ______________

Veteran: *(Circle One)* Yes No

Disabled: *(Circle One)* Yes No

Primary Medical Coverage: ____

Primary Pharmacy:_____________________________Address ____

Birth Sex: *(Circle one)* Female Male **For billing purposes*

Gender Identity: *(Circle one)* Male/Man Female/Woman TransMale/TransMan TransFemale/TransWoman

Genderqueer/Gender Nonconforming Decline to Answer Something Else, please describe_____________________

Sexual Orientation: *(Circle one)* Straight or Heterosexual Lesbian, Gay, or Homosexual Bisexual

Something Else, please describe_________________ Decline to Answer

Preferred Pronouns: *(Circle one)* He, Him, His She, Her, Hers They, Them, Theirs

Ze, Hir Unknown Decline to Answer Something Else, please describe_________________

Patient (Or Guardian) Consent for Treatment:

I authorize the providers of Amador Health Center to examine, diagnose, and recommend treatment for me or the person under my care.

ASSIGNMENT OF BENEFITS TO PROVIDER:

I only certify that the information provided on this form is correct to the best of my knowledge.

X___________________________

Patient Signature

____

Print Name of Patient

____

Date Relationship

AMADOR HEALTH CENTER NO SHOW POLICY

Amador Health Center works diligently to see all patients that come in to see a provider. Because of that reason we will only allow 3 no-shows. After that, appointments will not be made for you. You will only be seen as a walk-in and may experience long waiting times. Please call us if you are unable to make your appointment at (575)-527-5482.

I have read this policy and understand.

Signature________________________________Date_______________________

Print Name________________________________

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

____ __________________________

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Amador Health Center may use or disclose my protected health information for treatment, payment, or health care operations- which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures for this information without my authorization.

Amador Health Center has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Amador Health Center will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Amador Health Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Amador health center has taken action relying on this consent.

____ ________________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

____ ________________

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting:
Amador Health Center
999 W. Amador, Suite A
Las Cruces, NM 88005
Phone: 575-527-5482
Fax: 575-652-4243

Medical History

Name:____**Date of Birth:**_______/______/_______

Please indicate if **YOU** have a history of the following:

- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Problems
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Blood Clots
- ☐ Blood Transfusion(s)
- ☐ Bowel Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung/ Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Reflux/ GERD
- ☐ Seizures/ Convulsions
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/ CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Disease
- ☐ Ulcer
- ☐ Other Disease, Cancer, or Significant Medical Illness/
- ☐ **NONE of the above**

List other medical problems: ____

____

____

Medication Allergies

Name____________________________________Reaction You Had ____

☐ I have no known **Medication** allergies

Family Medical History

Please indicate if **YOUR FAMILY** has a history of the following:
(**ONLY** include parents, grandparents, siblings, and children)

- ☐ I am adopted and do not know biological family history
- ☐ Family History Unknown
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bleeding Disease
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Lung / Respiratory Disease
- ☐ Other Cancer
- ☐ Rectal Cancer
- ☐ Seizures/ Convulsions
- ☐ Stroke/ CVA of the Brain
- ☐ Thyroid Problems
- ☐ Mother, Grandmother, or Sister developed heart disease before the age of 65
- ☐ Father, Grandfather, or Brother developed heart disease before the age of 55
- ☐ **NONE of the Above**

Preventative History

Colonoscopy: ☐Y ☐N
Date: __________

Have you had a Tetanus shot?
☐Y ☐N If yes, how long ago?____

For Women
Papsmear: ☐Y ☐N Date: _______

For Men
Prostate Cancer Screening:
☐Y ☐ N Date:____________

Social History

Do you drink alcohol? ☐Y ☐N
IF Yes, drinks/week: __________
Do you currently:
Smoke / Chew / Vape tobacco?
☐Y ☐N
If No, previously ☐Y ☐N
Years smoked___Packs/day_____
Do you drink Caffeine? ☐Y ☐N
Do you use illegal drugs? ☐Y ☐N

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Social History Questionnaire

Occupation: ____

Employment:______Full-time______Part-time______Retired______Unemployed______Not working due to WC injury

Marital Status:______Single______Married______Divorced______Widowed

Number of Children:_______________

Do you exercise? Yes / No **What type of exercise:**_______________**How often:** ____________________

Declaration Of Income Statement

I,____do hereby declare on (date)_______________that:
(Applicant's name) (Date)

My household consists of____persons and the following household members:________________________________

____

My household's gross income, for all household members 18 years and older, for the 30 day period prior to the date of the application assistance is $________________________

_______I DECLINE TO GIVE ANY INFORMATION AT THIS TIME

I understand I need proof of income in order to be on the sliding scale, I have documented proof and will be providing the following:_____Federal Income Tax return_____One month's worth of check stubs
____ Letter From Employer ____Letter From Federal Disability

I have no document proof of income at this time due to the following: ____Homelessness ____Have zero income
____Get paid cash

I certify that the adobe information for the income is true and correct to the best of my ability.

_X____ _______________
Signature Date

____ _______________
Reviewed by Date