Linda Ann Smith MD
101 Hospital Loop Suite 106
Albuquerque, NM 87109
Phone: 505-828-0404 fax: 505-797-2850

**PCP**:________________________Phone:________________**GYN**:_______________________phone:________________

**Other Doctors**______________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

**Patient full name**: ______________________________________________DOB:___________Age:_________

Sex: _________________ Marital status __________________SS#__________________________

Address:_______________________________City:_________________State:_____________Zip:_____________

Home Phone:________________________Cell phone:____________________Work Phone:__________________

Employer **(required)**:___________________ Address:_________________________________________________

**Spouse Name**:___________________ DOB:_____________SS#____________________Phone#______________

Employer **(required)**______________________Work Phone_________________Address:____________________

**Emergency contact**: ______________________________Phone________________

How will you pay for **today's** services:____self-pay **(due at time of service)**________insurance_______other_________

**Person financially responsible for this account if other than patient**:

Name:____________________DOB:_________________SS#______________________Phone #________________

**Primary Insurance**:_________________________________ Phone # (on card): _________________________

Address (on card)_______________________________City/State:__________________________Zip:____________

ID#:_______________________________________________Group#_______________________________________

Policy holder:__________________DOB:__________Employer**(required)**:________________________________

**Secondary Insurance**:__________________________________ Phone # (on card): _____________________

Address (on card)_______________________________City/State:______________________Zip:_______________

ID#:_______________________________________________Group#_______________________________________

Policy holder:________________________DOB:__________Employer**(required)**:___________________________

**I authorize Dr. Linda Smith to perform diagnostic procedures and treatment as may be necessary for proper medical care.**

FINANCIAL AGREEMENT AND INFORMATION RELEASE

I hereby assign all medical and/or surgical benefits, to include Major Medical benefits to which I am entitled, including Medicare, and other government sponsored programs, private insurance and any other health plans. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not paid by said insurance. Further, I understand that I am responsible for payment of all reasonable collection fees and any associated legal costs incurred in the collection of any past due account balance. I hereby authorize assignee to release all information necessary to secure the payment of said benefits.

Patient/parent Guardian Signature:______________________________________________Date:________________

Date of Visit: ______________ Patient Name: _________________________ DOB:____________

## BREAST HEALTH HISTORY

Please write clearly

Reason for current visit: ____________________________________________

Characteristics of the problem:

Location: ______________________Duration:______________________

Nature of symptoms: ____________________________________________

Do the symptoms change with your menstrual cycle/how? ______________________

Are there skin changes? __________ Are there Nipple Changes?_____________

Are there changes to your mammograms/How?______________________________

Where have you had your previous mammograms?______________________________

What are your concerns/questions about this problem? ______________________________

List all previous Breast problems/surgery/biopsy's you have had (if any): ______________________

____________________________________________________________

Have you had a history of radiation to the chest between the ages of 10 and 30? ______________________

Do you have Breast implants? ________ Indicate type and duration (if known): ______________________

Bra size:_______ Last menstrual period:________ #of pregnancies:__________ #of Deliveries:__________

How old were you when you had your first menstrual period?______________________

How old were you when youhad your first live birth?______________________

What type of birth control do you use? ______________________________

Have you taken any of the following medications for more then 3 months?

| | Duration | Last Taken |
|---|---|---|
| Birth control pills: _______ | _______ | _________ |
| Hormone Replacement Therapy: _______ | _______ | _________ |

List all Allergies (including medication allergies): ______________________________

______________________________________________________ Latex Allergy? ____________

List all of your Current medications:______________________________________________

____________________________________________________________

Do you use recreational drugs not prescribed by a physician? ______________________

Do you drink alcohol? ______________How many drinks per week? ______________

Do you smoke? __________How many packs per day? __________ How many years? __________

List all outpatients surgeries you have had:______________________________________

____________________________________________________________

List all inpatient surgeries you have had:______________________________________

____________________________________________________________

List all hospitalizations you have had that did not involve surgery: ______________________

____________________________________________________________

**CURRENT MEDICAL PROBLEMS:**

Do you have any of the following problems? Please check all that apply and describe.

- ☐ Bleeding problems ____________________
- ☐ Clotting problems ____________________
- ☐ Diabetes ____________________
- ☐ High blood pressure ____________________
- ☐ HIV/AIDS ____________________
- ☐ High Cholesterol ____________________
- ☐ Skin Cancer ____________________
- ☐ Head or Neck Cancer ____________________
- ☐ Thyroid problems ____________________
- ☐ Asthma ____________________
- ☐ COPD ____________________
- ☐ Angina ____________________
- ☐ CHF____________________
- ☐ Ulcers ____________________
- ☐ Hepatitis ____________________
- ☐ Kidney Problems ____________________
- ☐ Arthritis ____________________
- ☐ Lupus or Connective Tissue Problems ____________________
- ☐ Seizures ____________________
- ☐ Stroke ____________________
- ☐ Depression/Anxiety/Mental illness____________________
- ☐ Anesthesia problems ____________________
- ☐ Any others not listed ____________________

**FAMILY HISTORY**

Race/Ethnicity**:**____________________ Are you Ashkenazi Jewish( increased risk for breast cancer)?______________

**Family members with the following problems (check all that apply)**

| | You | Mom | Dad | M/Aunt | P/Aunt | MGM | PGM | Siblings |
|---|---|---|---|---|---|---|---|---|
| Nipple discharge | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Breast biopsy | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Abnormal cells in breast | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Breast Cancer | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Ovarian Cancer | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Lymphoma | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Gastrointestinal cancer | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Mastectomy | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| Fertility treatments | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |
| DES Exposure | ____ | ____ | ____ | ____ | ____ | ____ | ____ | ____ |

Medical problems of your father: ________________________________________

________________________________________

Medical problems of you mother: ________________________________________

________________________________________

Medical problems of your siblings: ________________________________________

________________________________________

Other serious family health problems:________________________________________

________________________________________

## Acknowledgement of Receipt of Notice

**Linda Ann Smith, MD**
**101 Hospital Loop NE Ste 106**
**Albuquerque, NM 87109**
**Office (505)828-0404 Fax (505)797-2850**

I hereby acknowledge that I read a copy of this medical practice's HIPAA patient's rights.

I would like to receive a copy of any amended Notice of Privacy Practices by sending a request to the Privacy Officer at the above address and phone number.

Yes_______ No_________

Signed: ______________________ Date ________________

Printed name __________________ Telephone: ______________

If not signed by patient indicate relationship to patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____________________________

---

*For office use only:*

Signed form received by: ______________________

Acknowledgement refused:

Efforts obtained/reason for refusal: _________________________________

---

# RECORDS RELEASE AUTHORIZATION

I, ______________________________________ hereby authorize the release of all medical records:

To:

**Linda Ann Smith, MD**
**101 Hospital Loop NE Suite 106**
**Albuquerque, NM 87109**
**Office (505)828-0404 Fax (505)797-2850**

To: Any and all providers necessary for the continuation my care (to include Doctors and Facilities)

To: Any doctors listed below for correspondence

To: The following people: ______________________________________________________

______________________________________________________________________________

Patient Name:____________________________________________________

DOB:__________________________________________________________

Patient Signature:_________________________________________________

Date:__________________________________________________________

Witnessed:______________________________________________

Addresses required for correspondence:

Primary Care Physician:

______________________________

______________________________

______________________________

Gynecologist:

______________________________

______________________________

______________________________

Other Physicians/Specialists:

______________________________

______________________________

______________________________

Other Physicians/Specialists:

______________________________

______________________________

______________________________

**Linda Ann Smith, MD**
**101 Hospital Loop NE Ste 106**
**Albuquerque, NM 87109**
**Office (505)828-0404 Fax (505)797-2850**

## Financial Policy Office/Surgical

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Your applicable payment or co-payment for services is due at the time services are rendered. We accept cash, check, MasterCard, Visa, or Discover Card. If you have an HMO or PPO please provide us with the appropriate information. If you require a referral, please provide our office with that information. We will be happy to process your insurance claim form provided we have all of the required information to do so. Secondary insurance billing is a courtesy we offer; therefore claims will only be processed if you provide our office with the correct and necessary paper work needed to do so.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance to the extent we are able. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

We must emphasize that as health care providers, our relation is with you, not your insurance company. Assisting in the filing of insurance claims is a courtesy we extend to our patients. All charges are your responsibility from the date the services are rendered.

If you have any questions about the above information, or any uncertainty regarding payment, PLEASE do not hesitate to ask us. We are here to help you.

__________________________________
Signature of Patient/Responsible Party

__________________________________
Date