

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: _____

Nature of symptoms: _____

List all allergies (including medication and food allergies): _____

_____ Latex Allergy? _____

List all of your current medications (including vitamins and herbal supplements): _____

Do you smoke? _____ How many packs per day? _____ How many Years? _____

List all surgeries and hospitalizations you have had since your last visit? _____

Current medical problems:

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

Bleeding/Clotting problems: _____

High cholesterol: _____ High blood pressure: _____

Diabetes: _____

Skin Cancer: _____ Head or neck cancer: _____

Thyroid problems: _____

Asthma: _____ COPD: _____

CHF: _____ Angina: _____

Ulcers: _____

Hepatitis: _____

Kidney Problems: _____

Arthritis: _____

Lupus or connective tissue problems _____

Seizures: _____ Stroke: _____

Depression/anxiety/mental illness: _____

Anesthesia problems: _____

Any others not listed above: _____

Signature: _____ Date: _____