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:_____