Affiliated Clinics: SMG Primary Care, SMG Women's and Family Health, SMG Specialty Care, SMG Mancos Valley, SMG Pulmonary and Sleep, Southwest Walk-In Care, Southwest School-Based Health Center

NOTICE TO OUR PATIENTS

Thank you for choosing us as your healthcare provider. We look forward to providing an office environment and provider relationship that meets you and/or your family's medical needs.

Items to bring to your first appointment:

1. Driver's license or other photo identification.
2. All insurance cards.
3. Co-pays or payment in full at the time of your visit if you are not covered by insurance.
4. Actual bottles of all medications (prescribed and over the counter) that you are currently taking.

No-Show Policy

Our policy is to call patients the business day prior to their scheduled appointment to remind them of the appointment date and time. We perform these calls as a courtesy to our patients and to allow us the opportunity to reschedule the time slot should the appointment not be necessary. A phone call from you to cancel your appointment will allow us to schedule another patient that needs to be seen. Recognizing that everyone's time is valuable and that appointment time is limited, we ask that you provide **24 hours notice** if you are unable to keep your appointment. This will allow us to call one of our patients on a waiting list to fill the available slot on the schedule.

To improve care for our patients, we will track all "No-Show" visits. Each patient will be allowed to miss two scheduled appointments within a **one year period** without penalty. Once a third appointment is missed, the patient will be at risk of being discharged from the practice or the Southwest Medical Group. To prevent this from happening, patients shall receive a letter each time they no-show for an appointment reminding them of our no-show policy.

For the purposes of this policy, a no-show appointment is defined as follows:

1. An appointment which is missed by the patient without any advance notice.
2. An appointment that is cancelled less than 24 hours prior to the scheduled appointment time.
3. An appointment in which the patient arrives 10 minutes or more beyond the scheduled appointment time.

Failure to show for the initial "new patient" appointment may eliminate your opportunity to establish care as a new patient.

Rx Refill Policy

Our policy is to refill patient prescriptions within 72 (business) hours of receiving the request. Please do not wait until you are completely out of medication or you will likely do without until the refill can be processed.

Signed (signature required):

Patient, Parent or Legal Guardian:___________________________________ Date:______________________.

NEW PATIENT / HISTORY INFORMATION

Date:______________________

Patient Name: ____
First Name Middle Name Last Name

Date of Birth:__________________ Age:_____________ Gender: Male Female

Street Address:_________________________________ City/State/Zip:__________________________

Mailing Address (if different):______________________ City/State/Zip:__________________________

Best Contact Number:___________________________

Home Phone:___________ Cell Phone:________________ Work Phone:__________________

Email Address:____

Would you like to sign up for our Southwest Medical Group patient portal? ☐ No ☐ Yes

Social Security #_______ - _______ - _______ Primary Care Physician:______________________

Language:______________ Race: [American Indian or Alaska Native/ Native American /

African American / Asian / Chinese / Filipino / Japanese / White / Hispanic / Native Hawaiian / Other]

Marital Status: [Single Married Separated Divorced Widowed] Number of Children_________

Occupation:____ Retired? Y / N

Patient's Employer:____

Business Address:___________________________________ Phone: _____________________

Name of Primary Insurance:_________________ Name of Primary Insurance Holder:____________

Member ID#:_____________________________ Group #:______________________________

Name of Secondary Insurance:____

Member ID#:_____________________________ Group#:_______________________________

Patient's Relationship to Insurance Holder:____

In case of Emergency, who should be notified? Name:_________________________________

Relationship to Patient:____________________ Contact Phone Number:____________________

Patient Name: ____ Date of Birth: ____________
First Name Middle Name Last Name

SOUTHWEST MEDICAL GROUP
WOMEN'S AND FAMILY HEALTH
An Affiliate of Southwest Health System

FAMILY MEDICINE
OBSTETRICS
GYNECOLOGY

OB/PRENATAL QUESTIONNAIRE

(Confidential)

Patient Name:_______________________________________ Date of Birth:______________________

Referred By: ☐ Self ☐ Friend ☐ Dr. ______________________ ☐ Other:__________________________

OB provider preference: ____

CURRENT MEDICATIONS AND ALLERGIES

If you are currently taking any medication(s), or have taken any since you have been pregnant (include any Over the Counter Medications), please complete the information about these drugs below:

Name of Medication	Date Started/Recent Dose	Reason for Taking	Prescribing Doctor's Name

Preferred Pharmacy: ________________________________ Location:___________________________

Please list any known allergies and what type of reactions:

____

OB INITIAL INTAKE

Positive Urine Pregnancy Test by: ☐ self ☐ other: ___________ Occupation: ________________________

Type of work: _____________________ Education (highest level completed):______________________

If you do heavy labor or exercise, please describe: ____

Number of children at home: ______

Please list people living in household with you:

Name	Age	Relation to You

Planned Hospital of Delivery (if other than Southwest Memorial):_____________________________________

Planned Newborn's Provider (if other than your Southwest Medical Group provider): ______________________

FATHER OF BABY (FOB)

Will the father of the baby be involved?

If yes, name of husband/father of baby: ________________________ FOB Occupation: _________________

FOB Phone Number: __________________ FOB Highest level of Education: __________________________

Form # 6800-F109
11/13/2018

SOUTHWEST MEDICAL GROUP
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Was this pregnancy unplanned? ☐ Yes ☐ No

Are you or the baby's father unhappy about this pregnancy? ☐ Yes ☐ No If yes, who: ___________________

Have you ever tried, but could not get pregnant for over 1 year? ☐ Yes ☐ No

MENSTRUAL HISTORY

Date **LAST** menstrual period (LMP) **began:** ______ / ______ /20______
LMP character: ☐ Light ☐ Normal ☐ Heavy
How certain are you of the month? ☐ Very certain ☐ Unsure Of the date? ☐ Very certain ☐Unsure
Do you know the date of conception? ☐ Yes ☐ No If yes, what date? ______ / ______ / 20___
Menarche (age when periods began): __________
Menses Interval (how many days between periods): _______ Days
Approximate length of menstrual flow: _______ Days
Were you on Birth Control Pills at conception? ☐ Yes ☐ No If yes, date you took last pill: __________
If you used another method of birth control just before or since your LMP, what was it? ___________
Date of Home Pregnancy Test: ______ / ______ /20______
Pre-Pregnancy Weight: __________ lbs.
Symptoms since LMP: ☐ amenorrhea (no menses) ☐ nausea ☐ vomiting ☐ fatigue ☐ irritability ☐ bloating
☐ tender breasts ☐ urinary frequency ☐ other: __________________
Have you experienced any of the following since your LMP?
Pain: ☐ Yes ☐ No If yes, please explain: ____
Bleeding: ☐ Yes ☐ No Spotting: ☐ Yes ☐ No Discharge: ☐ Yes ☐ No
Any other medical problem or accidents since your LMP? ______________________________________

PAST MEDICAL HISTORY

Did you have diabetes, high blood pressure, bleeding, depression or any other medical problem during a previous pregnancy? ☐ Yes ☐ No If yes, list the problems: _______________________________________
Are you on a special diet? ☐ Yes ☐ No If yes, what type: ____
Do you have any abnormality of female organs (uterus/cervix)? ☐ Yes ☐ No
If yes, please explain: ____
Date of last pap smear: ______ / ______ /20______
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
If yes, what type of treatment if any did you have to cervix or uterus? __________________________

Please indicate if you, the father of the baby, or any of your family members have a history of the following:

Disease/Condition	Yourself	Baby's Father	Family Members
Asthma/Lung Problems/Tuberculosis			
Cancer (What type?)			
Convulsions (Epilepsy)			
Diabetes			

Drinking problems			
Heart trouble below age 50			
High Blood Pressure			
Kidney Disease			
Thyroid trouble			
Trouble with Nerves/Depression			

SOCIAL HISTORY/RISK FACTORS

What is your religious preference? ___________________ FOB's religious preference? _________________
Do you smoke cigarettes? ☐ Yes ☐ No If yes, how much? ____________ For how many years? ____________
Do you use any other tobacco products? ☐ Yes ☐ No If yes, what type? ________________________________
Do you drink alcohol? ☐ Yes ☐ No If yes, what type of drinks?___________ How much in one week? _________
Have you or any of your sexual partners ever used any street drugs? ☐ Yes ☐ No If yes, who? _____________
If yes, did either of you ever inject (shoot up) any drugs? ☐ Yes ☐ No If yes, type? ________________________

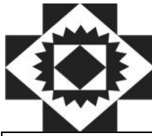
Within the past year, have you been threatened or physically hurt by someone in any way?
☐ Yes ☐ No Since being pregnant? ☐ Yes ☐ No If yes, please explain:
____
____

Have you been forced to perform any sexual act that you did not want to do? ☐ Yes ☐ No If yes, please explain:
____

PAST PREGNANCY HISTORY

Please list details for all of your previous pregnancies below. If this is your FIRST pregnancy, please skip to Genetic History section.

Child's Name	Date of Birth	Birth Weight	Sex	Type of Delivery	Location	Complications
		lbs. oz.	☐ M ☐ F	☐Vaginal ☐C-Section		
		lbs. oz.	☐ M ☐ F	☐Vaginal ☐C-Section		
		lbs. oz.	☐ M ☐ F	☐Vaginal ☐C-Section		
		lbs. oz.	☐ M ☐ F	☐Vaginal ☐C-Section		
		lbs. oz.	☐ M ☐ F	☐Vaginal ☐C-Section		
		lbs. oz.	☐ M ☐ F	☐Vaginal ☐C-Section		



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		lbs. oz.	□ M □ F	□Vaginal □C-Section		
		lbs. oz.	□ M □ F	□Vaginal □C-Section		

Did you experience early labor or were any babies premature or overdue? □ Yes □ No

If yes, how many weeks? __________

Did you ever lose a pregnancy (by abortion, miscarriage, stillbirth, or ectopic (tubal) pregnancy? □ Yes □ No

If yes, dates and type: ____

Did you ever lose a child that was born alive? □ Yes □ No

Were any of your babies born breech? □ Yes □ No

Were any of your babies born with birth defects or deformities? □ Yes □ No If yes, list: __________________

Did any of your babies develop jaundice, infection, or any other problems during the first two weeks of life?

□ Yes □ No If yes, please explain: ____

GENETIC HISTORY

Will you be 35 years or older at the time the baby is born? □ Yes □ No

Please indicate if you, the baby's father, or any family members have or have experienced any of the following:

Disease/Condition	Yourself	Baby's Father	Family Members
Thalassemia (blood disorder)			
Neural Tube Defect			
Down's Syndrome			
Tay-Sachs (rare nerve disorder)			
Sickle Cell Disease/Trait			
Hemophilia			
Muscular Dystrophy			
Cystic Fibrosis			
Huntington's Disease			
Mental Retardation			
Fragile X			
Other Genetic/Chromosomal			
Other Birth Defects/Inherited Diseases (cleft lip, clubfoot, or any others)			

Hearing loss in infancy			
More than 3 miscarriages			
History of Stillbirth			
Multiple Births (twins, triplets, etc.)			
Come from the Philippines, Mediterranean Area, or S.E. Asia			
Lived in Africa or Haiti			

INFECTION HISTORY

Are you at risk for Hepatitis B (multiple partners, IV Drug use, partners with Aids, etc)? ☐ Yes ☐ No
Have you been immunized against Hepatitis B? ☐ Yes ☐ No
Have you ever been exposed to TB? ☐ Yes ☐ No
Do you have a history of Genital Herpes? ☐ Yes ☐ No
Have you had a sexual partner with Genital Herpes? ☐ Yes ☐ No
Have you ever had a STD (Gonorrhea, Chlamydia, Syphilis, HPV)? ☐ Yes ☐ No If yes, type: _______________
Since your LMP, have you had a fever, rash or viral illness? ☐ Yes ☐ No If yes, type: _____________________
Are you exposed to cat litter? ☐ Yes ☐ No
Have you had the chicken pox? ☐ Yes ☐ No Or the vaccine? ☐ Yes ☐ No
Have you ever had Parvovirus (Fifth Disease)? ☐ Yes ☐ No

Do you have occupational exposure to children? ☐ Yes ☐ No
If yes, which? ☐ ☐Daycare ☐ Teacher ☐ Other: _______________

ENVIRONMENTAL EXPOSURES

Are you exposed to X-rays? ☐ Yes ☐ No
Are you exposed to chemicals or other hazardous materials? ☐ Yes ☐ No

Comments:____

____

____

Patient Signature: ____ Date: ____________________

CONSENT FOR OB PATIENT
DRUG AND/OR ALCOHOL TESTING

Patient's Name: ________________________________ Date of Birth: __________________

Thank you for choosing us to provide your maternity care. In order to help you and your physician make better decisions regarding your prenatal treatment, it is our policy to perform drug and/or alcohol screening for all initial obstetrics visits. Additional or repeat screening may be performed as deemed necessary by your physician for the duration of your maternity care with our office.

By my signature below, I acknowledge that I have read and understood the information in this consent. Further, I acknowledge that I have given consent for the performance of drug and/or alcohol testing as deemed necessary by my physician or his/her designee. Testing will be performed by employees of Southwest Health System, Inc. Results of testing will be released as needed for appropriate medical treatment.

Signature: ____Date: ___________________

If signed by other than patient, indicate relationship to patient: ____________________________

This consent may be signed by a person other than the patient, only under the following circumstances:

1. The patient is under 12 years of age or, as a result of his/her physical condition, is unable to provide consent.

2. The person who consents to the testing on the patient's behalf is lawfully authorized to make healthcare decisions for the patient.

3. It is necessary to obtain the patient's test results in order to render appropriate care to the patient or to practice prevention measures per Health and Safety Codes section 119.27

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Cystic Fibrosis/Spinal Muscular Atrophy/Fragile X Carrier Testing

As of March 2017, the American College of Obstetrics and Gynecology recommends that carrier screening for both Cystic Fibrosis and Spinal Muscular Atrophy be made available for all patients who are pregnant or considering pregnancy. We also offer genetic carrier testing for Fragile X Syndrome.

Cystic Fibrosis (CF) is characterized by the buildup of thick, sticky mucus that can damage many of the body's organs. The disorders most common signs and symptoms include progressive damage to the respiratory system and chronic digestive system problems. The features of the disorder, and their severity, varies among affected individuals. CF does not affect a person's learning ability or his/her appearance. More than 25,000 American children and young adults have CF; about 850 cases of CF are diagnosed each year.

Spinal Muscular Atrophy (AMA) is a disorder that affects the control of muscle movement. It is caused by a loss of specialized nerve cells, called motor neurons, in the spinal cord and the brainstem. The loss of motor neurons leads to weakness and atrophy of muscles used for activities such as crawling, walking, sitting up and controlling head movement. In severe cases of SMA, the muscles used for breathing and swallowing are affected. There are many types of spinal muscular atrophy distinguished by the pattern of features, severity of muscle weakness, and age when the muscle problems begin.

Most people have two normal copies of these genes. Carriers have one normal and one abnormal gene. CF and AMA are autosomal recessive conditions (meaning you get one abnormal gene from each parent) found more commonly in individuals of Caucasian decent. When both parents are carriers (one normal and one abnormal copy of the gene) there is a 25% chance to have an affected child with each pregnancy. An affected child has two abnormal copies of the gene. If both parents are documented carriers, prenatal diagnosis is available via more invasive specialized testing (amniocentesis or CVS).

Fragile X Syndrome is a genetic disorder with symptoms of mild to moderate intellectual disability and unusual physical features such as large ears, narrow long face and flexible fingers. It is typically more severe in males compared to females and is twice as common in males (1-3600 males). There are often features of autism and seizures as well. This disorder is due to genetic mutations of the X gene.

Cost and insurance coverage for genetic carrier testing depends upon your insurance policy. Insurance companies may or may not cover the cost of testing. If you choose to have the testing and it is not covered by your insurance company, you would be responsible for the cost.

My provider has reviewed the above with me and answered my questions.

_________ No, I am not interested in CF/SMA/Fragile X Carrier testing.

_________ Yes, I would like to have CF/SMA/Fragile X Carrier testing.

Patient Signature: ____ Date:_________________________

Provider Signature:____ Date:_________________________

CONSENT FOR THE HIV TEST

Patient's Name: ____ MR#: ____________________________

I am consenting to be tested to see whether I have been infected with the Human Immunodeficiency Virus (HIV) which is the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS).

THE MEANING OF THE TEST: This test is not a test for AIDS, but only for the presence of HIV. Being infected with HIV does not mean that I have AIDS or that I will have AIDS or other related illnesses. Other factors must be reviewed to determine whether I have AIDS.

Most test results are accurate, but sometimes the results are wrong or uncertain. In some cases the test results may indicate that the person is infected with HIV, when the person is not (false positive). In other cases the test may fail to detect that a person is infected with HIV, when the person really is (false negative). Sometimes, the test cannot tell whether or not a person is infected at all. If I have been recently infected with HIV, it make take some time before a test will show the infection. For these reasons, I may have to repeat the test.

CONFIDENTIALITY: State law limits the disclosure of my HIV test results. Under the law, no one but my physician and care givers are told about the test results, unless I give specific written consent to let other people know. Additionally, physicians may inform my spouse, any sexual partner(s) or needle sharing partner(s) or the county health officer, if a physician thinks it is necessary. All information relating to the test is kept in my medical records.

BENEFITS AND RISKS OF THE TEST: The test results can help me make better decisions about my healthcare and my personal life. The test results can help me and my physician make decisions concerning medical treatment, if the results are positive. I know that I can infect others and I can act to prevent this.

Potential risks of the test include psychological stress while awaiting the results and distress, if the results are positive. Some persons have had trouble with jobs, housing, education or insurance when their test results have been made known.

MORE INFORMATION: I understand that before I decide to take this test, I should be sure that I have had the chance to ask my physician any questions I may have about the test, its meaning, its risks and benefits and any alternatives to the test.

By my signature below, I acknowledge that I have read and understood the information in this form, that I have been given all of the information I desire concerning the HIV test, its meaning, expected benefits, possible risks and any alternative to the tests, and that I have had my questions answered. Further, I acknowledge that I have given consent for the performance of a test to detect HIV.

Date: ______________________________ Time: _______________ AM/PM

Signature: ____
(patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship* ____

Witness: ____

*This consent may be signed by a person other than the patient, only under the following circumstances:

1. The patient is under 12 years of age or, as a result of his/her physical condition, is incompetent to consent to the HIV antibody blood test, and
2. The person who consents to the test on the patient's behalf is lawfully authorized to make healthcare decisions for the patient, (i.e., an attorney-in-fact appointed under the Durable Power of Attorney for Healthcare, the parent or guardian of a minor, an appropriately authorized conservator, or under appropriate circumstances, the patient’s closest relative, and
3. It is necessary to obtain the patient's HIV antibody test results in order to render appropriate care to the patient or to practice preventative measures per Health and Safety Codes section 199.27.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:	Phone Number: ______________________
Address:	Date of Birth: ______________________
	Last 4 digits SSN#: ______________ (optional)

I, ____, hereby authorize disclosure of my protected health information as follows:

RELEASE FROM:

Facility, Person, Provider:	Phone Number: ________________________________
Address:	Fax Number: ________________________________*
	E-mail: ____ (e-mailed information will be encrypted)

RELEASE TO:

Facility, Person, Provider:	Phone Number: ________________________________
Address:	Fax Number: ________________________________*
	E-mail: ____ (e-mailed information will be encrypted)

***SHS DOES NOT FAX PERSONAL HEALTH INFORMATION TO HOME FAX MACHINES**

Information to be released: From (date) ____________________________ to (date) ______________________________

☐ Treatment Records-Hospital ☐ Laboratory Reports ☐ Emergency Room Records ☐ History and Physical
☐ Office Visit Notes - Clinic ☐ Diagnostic Imaging Reports ☐ Discharge Summary ☐ Pathology Reports
☐ Consultation Reports ☐ Operative Reports ☐ Ambulance Run Reports ☐ Sleep Lab Reports
☐ Other, list below:

____.

Purpose of Release: ☐ Medical Care ☐ Transferring Care ☐ Attorney ☐ Personal Records ☐ Other: ______________________________.

Sensitive Information: I understand by checking any boxes below, I have given permission to release confidential information related to HIV, Mental Health Care, or Drug and Alcohol Treatment, which is protected by federal law 42 CFR Part 2. (If the boxes are not checked, this information will **NOT** be released.)

☐ Diagnosis and/or treatment relating to drug or alcohol abuse
☐ Diagnosis and/or treatment relating to mental health conditions
☐ Diagnosis and/or treatment relating to HIV testing, infection or diagnosis and/or treatment for AIDS

Right to Revoke: I understand that I may revoke this Authorization at any time by notifying Southwest Health System, Inc., in writing. I understand that revocation will not have any effect on actions taken prior to receipt of the revocation.

Expiration: This Authorization will automatically expire 180 days from the date of my signature, unless otherwise specified as follows: _______________(date).

Re-Disclosure: I understand that the information used and/or disclosed according to this Authorization may no longer be protected by federal privacy law also known as HIPAA, and the recipient of the health information may potentially re-disclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

With my signature below, I acknowledge and authorize Southwest Health System, Inc., to use and/or disclose my protected health information as described above. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this Authorization.

Patient name printed: ____ Date of Signature: ______________/Time:______________

Patient signature: ____

Patient representative name printed: ____________________________________

Patient representative signature: ____________________________________/ Relationship to Patient: ____________________________