Thank you for choosing Rio Grande Internal Medicine, P.C.! We strive to provide the best medical care. It is our pleasure to welcome you as a patient. We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Before you arrive collect the following to bring to your first appointment:

- Filled out New PATIENT PACKET that is attached. This will include a list of your current medications. If you do not fill out the packet prior, please arrive 20 minutes early to fill out the forms.
- Insurance Card
- Medical records (or have them faxed over)
- Copayment, coinsurance and/or deductible is due at office visit, if applicable.

If you have any questions about the form or your appointment, call us at 505.792.2636. We look forward to meeting you!
Welcome to our office. We appreciate your selection of this office to serve your health needs. Please provide us with the following information so that we may get to know you better.

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
<th>PHONE &amp; EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: ______________</td>
<td>Email Address: ________________________</td>
</tr>
<tr>
<td>Soc. Sec. #:________</td>
<td>Home Phone: ________________________</td>
</tr>
<tr>
<td>Last Name:__________</td>
<td>Cell Phone: ________________________</td>
</tr>
<tr>
<td>First Name:_________</td>
<td>Work Phone: ________________________</td>
</tr>
<tr>
<td>Home Address:_______</td>
<td>In Case of Emergency Contact:</td>
</tr>
<tr>
<td>City:_______________</td>
<td>Name: __________________________</td>
</tr>
<tr>
<td>State: ________</td>
<td>Relationship to you: ______________</td>
</tr>
<tr>
<td>Postal Zip Code: _____</td>
<td>Home Phone: ________________________</td>
</tr>
<tr>
<td>Date of Birth:________</td>
<td>Cell Phone: ________________________</td>
</tr>
<tr>
<td>Preferred Name:________</td>
<td>Work Phone: ________________________</td>
</tr>
</tbody>
</table>
| Occupation:_________ | Marital Status: ______________ Name of spouse: __________________
| Company Name:_______ | (if applicable) |
| Company Address:____________________________ | Email Address: ________________________ |
| Marital Status: ______________ | Home Phone: ________________________ |
| Name of spouse: ______________ | Cell Phone: ________________________ |

<table>
<thead>
<tr>
<th>INSURANCE INFORMATION</th>
<th>INSURANCE EDUCATION &amp; CERTIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Primary Insurance Co.: __________________</td>
<td>We encourage you to educate yourself on your insurance plan(s). Remember that most insurance companies have co-payments, co-insurances and sometimes deductibles.</td>
</tr>
<tr>
<td>Name of Responsible person on Account: ______________</td>
<td></td>
</tr>
<tr>
<td>Relationship to Patient: __________________</td>
<td>It is our policy at Rio Grande Internal Medicine to collect any out of pocket expenses, such as copay, deductible, co-insurance or any previous outstanding balances at the time of your visit.</td>
</tr>
<tr>
<td>Birthdate: ______________</td>
<td>I certify that I have coverage with:</td>
</tr>
<tr>
<td>Soc. Sec. #:____________</td>
<td>(name of Ins. company(ies)</td>
</tr>
<tr>
<td>Primary Insurance Member ID #:____________________</td>
<td>and assign directly to Dr. Goodluck all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.</td>
</tr>
<tr>
<td>Primary Insurance Group #:____________________</td>
<td>Patient Signature: __________________</td>
</tr>
<tr>
<td>Name of Secondary Insurance Co.: __________________</td>
<td></td>
</tr>
<tr>
<td>Name of Responsible person on Account: ______________</td>
<td>Date: __________________</td>
</tr>
<tr>
<td>Relationship to Patient: __________________</td>
<td></td>
</tr>
<tr>
<td>Birthdate: ______________</td>
<td></td>
</tr>
<tr>
<td>Soc. Sec. #:____________</td>
<td></td>
</tr>
</tbody>
</table>
## CURRENT MEDICATION REGIMEN

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## MEDICATION ALLERGIES

<table>
<thead>
<tr>
<th>Medication or Substance</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## FAMILY HISTORY

<table>
<thead>
<tr>
<th>Alive</th>
<th>Deceased</th>
<th>Present Health or Cause of Death</th>
<th>Present Health or Cause of Death</th>
<th>Spouse</th>
<th>Present Health or Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mother</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Spouse</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Brothers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>How many deceased</td>
<td>Cause of death</td>
</tr>
<tr>
<td>Sisters</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>How many deceased</td>
<td>Cause of death</td>
</tr>
<tr>
<td>Children</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>How many deceased</td>
<td>Cause of death</td>
</tr>
</tbody>
</table>

Check any illnesses which have occurred in ANY of your BLOOD RELATIVES:
- ☐ Diabetes
- ☐ Stroke
- ☐ Bleeding tendency
- ☐ Tuberculosis
- ☐ Heart disease
- ☐ Allergy
- ☐ High blood pressure
- ☐ Other___________
- ☐ Cancer
- ☐ Kidney disease
- ☐ Nervous illness
- ☐ Other___________
- ☐ Other___________
- ☐ Other___________

## HEALTH HABITS

Check (✓) which one you use and how much:
- ☐ Caffeine
- ☐ Street Drugs
- ☐ Tobacco
- ☐ Stress
- ☐ Heavy lifting
- ☐ Other___________
- ☐ Alcohol
- ☐ Other___________
- ☐ Hazardous Substances
- ☐ Other___________

Check (✓) if your work exposes you to:
- ☐ Stress
- ☐ Heavy lifting
- ☐ Other___________
- ☐ Hazardous Substances
- ☐ Other___________

## Past Health

List of Surgeries and Operations:

Last Physical Exam Reason:

[Table with columns for medication list and allergy list]

[Table with columns for family history and health habits]

[Table with columns for past health and last physical exam reason]
### Patient Information

**Patient Name** __________________________________________ **Date** ______________________

**Age** ________ **Date of Birth** ________________ **Date of last physical examination** ________________

**What is your reason for visit?** ______________________________________________________

### Symptoms

**SYMPTOMS** Check symptoms you currently have or have had in the past year:

<table>
<thead>
<tr>
<th>GENERAL</th>
<th>GASTROINTESTINAL</th>
<th>EYE, EAR, NOSE, THROAT</th>
<th>MEN ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Chills</td>
<td>□ Appetite poor</td>
<td>□ Bleeding gums</td>
<td>□ Breast lump</td>
</tr>
<tr>
<td>□ Depression</td>
<td>□ Bloating</td>
<td>□ Blurred vision</td>
<td>□ Erection difficulties</td>
</tr>
<tr>
<td>□ Dizziness</td>
<td>□ Bowel changes</td>
<td>□ Crossed eyes</td>
<td>□ Lump in testicles</td>
</tr>
<tr>
<td>□ Fainting</td>
<td>□ Constipation</td>
<td>□ Difficulty swallowing</td>
<td>□ Penis discharge</td>
</tr>
<tr>
<td>□ Fever</td>
<td>□ Diarrhea</td>
<td>□ Double vision</td>
<td>□ Sore on penis</td>
</tr>
<tr>
<td>□ Forgetfulness</td>
<td>□ Excessive hunger</td>
<td>□ Earache</td>
<td>□ Other</td>
</tr>
<tr>
<td>□ Headache</td>
<td>□ Gas</td>
<td>□ Hay fever</td>
<td></td>
</tr>
<tr>
<td>□ Loss of sleep</td>
<td>□ Hernormhoids</td>
<td>□ Hoarseness</td>
<td></td>
</tr>
<tr>
<td>□ Loss of weight</td>
<td>□ Indigestion</td>
<td>□ Loss of hearing</td>
<td></td>
</tr>
<tr>
<td>□ Nervouness</td>
<td>□ Nausea</td>
<td>□ Nosebleeds</td>
<td></td>
</tr>
<tr>
<td>□ Numbness</td>
<td>□ Rectal bleeding</td>
<td>□ Persistent cough</td>
<td></td>
</tr>
<tr>
<td>□ Sweats</td>
<td>□ Stomat</td>
<td>□ Sinus problems</td>
<td></td>
</tr>
<tr>
<td>□ MUSCLE/JOINT/BONE</td>
<td>□ Arm</td>
<td>□ Vision – flashes</td>
<td></td>
</tr>
<tr>
<td>□ Back</td>
<td>□ Hips</td>
<td>□ Vision – halos</td>
<td></td>
</tr>
<tr>
<td>□ Feet</td>
<td>□ Legs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Hands</td>
<td>□ Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Shoulders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ GENITO-URINARY</td>
<td>□ Blood in urine</td>
<td>□ Bruise easily</td>
<td>□ Menstrual period: ______________</td>
</tr>
<tr>
<td>□ Frequent urination</td>
<td>□ Frequent urination</td>
<td>□ Hives</td>
<td></td>
</tr>
<tr>
<td>□ Lack of bladder control</td>
<td>□ Swelling of ankles</td>
<td>□ Itching</td>
<td></td>
</tr>
<tr>
<td>□ Painful urination</td>
<td>□ Varicose veins</td>
<td>□ Change in moles</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Rash</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Scars</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Sore that won’t heal</td>
<td></td>
</tr>
</tbody>
</table>

**CARDIOVASCULAR**

- □ Chest pain
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Poor circulation
- □ Rapid heart beat
- □ Swelling of ankles
- □ Varicose veins

**EYE, EAR, NOSE, THROAT**

- □ Bleeding gums
- □ Blurred vision
- □ Crossed eyes
- □ Difficulty swallowing
- □ Double vision
- □ Earache
- □ Hay fever
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Sinus problems
- □ Vision – flashes
- □ Vision – halos

**SKIN**

- □ Bruise easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Scars
- □ Sore that won’t heal

**MEN ONLY**

- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other

**WOMEN ONLY**

- □ Abnormal pap smear
- □ Bleeding between periods
- □ Breast lump
- □ Extensive menstrual pains
- □ Hot flashes
- □ Nipple discharge
- □ Vaginal discharge
- □ Other

**Date of last Menstrual period:** ______________

**Date of last Pap Smear:** ______________

**Are you pregnant?** Y / N

**Number of Children:** ____________

### Conditions

**CONDITIONS** Check conditions you have or have had in the past:

- □ AIDS
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Appendicitis
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chemical Dependency
- □ Chicken Pox
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Gotier
- □ Gonorrhea
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High Cholesterol
- □ HIV Positive
- □ Kidney Disease
- □ Liver Disease
- □ Measles
- □ Migraine Headaches
- □ Miscarriage
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate Problem
- □ Psychiatric Care
- □ Rheumatice Fever
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid Fever
- □ Ulcers
- □ Vaginal Infections
- □ Veneral Disease
<table>
<thead>
<tr>
<th><strong>AUTHORIZATION FOR RELEASE OF INFORMATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name:</strong></td>
</tr>
<tr>
<td><strong>Date of Birth:</strong></td>
</tr>
<tr>
<td><strong>Social Security Number:</strong></td>
</tr>
<tr>
<td><strong>Patient Address:</strong></td>
</tr>
<tr>
<td><strong>Telephone Number:</strong></td>
</tr>
<tr>
<td><strong>Purpose for Record Request:</strong></td>
</tr>
<tr>
<td>CONTINUATION OF CARE</td>
</tr>
</tbody>
</table>

I hereby request and authorize:

to release all my medical record to:

Rio Grande Internal Medicine, P.C.
4801 McMahon Blvd. NW, Suite 210
Albuquerque, NM 87114

PHONE (505) 792-25003  |  FAX (505) 727-2507

I understand the information may include information regarding drug or alcohol abuse, mental health and/or HIV related information. I release the above from all legal responsibility or liability that may arise from the act I have authorized.

I understand that this authorization is valid for one year after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with.

Date

Signature of Patient or Legal Representative

Legal Representative’s Relationship to Patient
REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

I, ________________________________ give permission to Dr. Goodluck’s office to discuss my protected health information (PHI) with named person below.

Those who we may communicate with regarding your health information, or for appointments:

Name: ____________________________________________
Relationship: ___________________________ Telephone(s): ___________________________

Name: ____________________________________________

Relationship: ___________________________ Telephone(s): ___________________________

Name: _______________________________________________________________________________________
Relationship: ___________________________ Telephone(s): ___________________________

NOTE: This request will remain in effect until you notify us of a change.

Signature: __________________________________ Date: ________________
Print Name: ________________________________
Relationship (if not patient, who is signing): ________________________________

Patient’s Date of Birth: ________________ Patient’s SS#: ________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The receptionist has the HIPAA Notice of Privacy Practices for you to review. Your name and signature on this cover sheet indicate that you have received a copy of HIPAA Privacy Practices.

If you have any questions regarding the information set forth in this notice, please do not hesitate to contact our office at 4801 McMahon Blvd NW suite 210 Albuquerque, NM 87114

Printed Name of Patient: ________________________________
Signature: __________________________________________________________________________
Authority to Sign if Not Patient: ________________________________
Date: ______________________________________________________________________________
OFFICE POLICY: MISSED APPOINTMENTS

As we strive to continually bring you great medical care we have implemented a new policy about no-show appointments. We understand that things come up and you may not always be able to make your appointment. Please give **24 hour notice** if you need to cancel your appointment, if you do not you will be charged a **$25.00** fee. This fee will NOT be covered by your insurance.

We do not send out appointment reminders, however, we do confirm appointments by telephone 1-2 days in advance. It is your responsibility to provide us with the correct contact information.

Thank you for taking the time to review these policies. If you have any further questions please feel free to ask any of our staff.

Patient Signature:_________________________________________ Date:________________________