SANTA FE IMAGING

Desert Rose Women's Center
AT SANTA FE IMAGING

1640 Hospital Drive
Santa Fe, NM 87505
TEL: 505-983-9350
FAX: 505-954-4253

PATIENT INFORMATION FORM

Last Name: First Name: Middle Name:

MRN: DOB: Gender: ☐ FEMALE ☐ MALE

Address 1:

Address 2:

City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Email:

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Preferred Language:

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Education Level: ☐ Minor ☐ No School Completed ☐ High School Diploma ☐ Some College ☐ College

RESPONSIBLE PARTY INFORMATION

Last Name: First Name: Middle Name:

Patient's Relationship to Responsible Party:

Address 1:

Address 2:

City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

EMERGENCY CONTACT INFORMATION

Name:

Patinet's Relationship to Emergency Contact:

Address:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Primary Insurance Information

For Medicare Patients: Are You or Your Spouse Working? ☐ YES ☐ NO If Yes, whom?

Primary Insurance Name: SELF PAY (notes) Plan Name:

Address:

City: State: Zip Code:

Policy #: Group # DOB:

Policy Holder Name:

Policy Holder Address:

City: State: Zip Code:

Patient's Relationship to Policy Holder:

Secondary Insurance Information

For Medicare Patients: Are You or Your Spouse Working? ☐ YES ☐ NO If Yes, whom?

Primary Insurance Name: SELF PAY (notes) Plan Name:

Address:

City: State: Zip Code:

Policy #: Group # DOB:

Policy Holder Name:

Policy Holder Address:

City: State: Zip Code:

Patient's Relationship to Policy Holder:

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Patient Name: DOB

Height: Weight:

MEDICAL INFORMATION

Is this visit related to an auto accident? ☐YES ☐ NO

Is this visit related to an injury sustained while at work? ☐YES ☐ NO

Date of Injury: _____/_____/_____

SMOKING STATUS:

☐ Current Every Day ☐ Current Some Days ☐ Never Smoked ☐ Smoker, current status unknown ☐ Former Smoker ☐ Unknown

ACTIVE MEDICATIONS: ☐ None

☐ ActoPlus Med	☐ Fortamet	☐ Glyburid Met	☐ PrandiMet
☐ Avandamet	☐ Glucophage	☐ Janumet	☐ Riomet (liquid form of Metformin)
☐ Diabex	☐ Glucovance	☐ Metaglip	
☐ Diafomin	☐ Glumetza	☐ Metformin	

MEDICAL HISTORY: ☐ None

☐ Aneurysm Clip/Coil	☐ Breast Implants	☐ Insulin Pump	☐ Paraplegic
☐ Aneurysm **Had Surgery**	☐ Cancer	☐ Metal in the Body	☐ Previous CT Contrast Reaction
☐ Aneurysm **NO Surgery**	☐ Diabetes	☐ Morphine Pump	☐ Previous MR Contrast Reaction
☐ Asthma	☐ Hypertension	☐ Pacemaker	☐ Renal Disease

ALLERGIES: ☐ None

☐ Adhesive Tape	☐Mild	☐Moderate	☐Severe	☐ Latex	☐Mild	☐Moderate	☐Severe
☐ Bee Sting	☐Mild	☐Moderate	☐Severe	☐ Lidocaine/Novacaine	☐Mild	☐Moderate	☐Severe
☐ Betadine (Topical Iodine)	☐Mild	☐Moderate	☐Severe	☐ Mold	☐Mild	☐Moderate	☐Severe
☐ Contrast (Med. Imaging)	☐Mild	☐Moderate	☐Severe	☐ Peanut or other nut	☐Mild	☐Moderate	☐Severe
☐ Dog, Cat, or Animal	☐Mild	☐Moderate	☐Severe	☐ Penicillin	☐Mild	☐Moderate	☐Severe
☐ Dust	☐Mild	☐Moderate	☐Severe	☐ Rubbing Alcohol	☐Mild	☐Moderate	☐Severe
☐ Fruit	☐Mild	☐Moderate	☐Severe	☐ Shellfish	☐Mild	☐Moderate	☐Severe
☐ Grass / Pollen	☐Mild	☐Moderate	☐Severe	☐ Sulfa Drug	☐Mild	☐Moderate	☐Severe

Mild allergic reactions include hives, itching, nasal congestion, rash and watery eyes.

Moderate allergic reactions include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomiting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconsciousness.

Severe allergic reaction is anaphylactic shock

TO OUR FEMALE PATIENTS

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members.
By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

_____ _____

Signature *Date*

Date of Last Menstrual Period: _____ /_____ /_____

AUTHORIZATION & AGREEMENT

CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize Santa Fe Imaging LLC to furnish the necessary medical or surgical treatments, or procedures, including diagnostic, x-ray and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or his designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment, diagnostic procedures in Santa Fe Imaging, LLC. I recognize that the physicians who practice at Santa Fe Imaging, LLC are not employees or agents of Santa fe Imaging, LLC but are independent physicians. Santa Fe Imaging, LLC may delegate to these independent physicians those services physicians normally provide, and any questions relating to care my physician has given or ordered should be directed to him/her.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to santa Fe Imaging, LLC of any and all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Santa Fe Imaging, LLC for charges not covered by this assignment. I also understand that Santa Fe Imaging, LLC is filing my claims as a courtesy to me and that unless stipulated in a contract with my carrier, I am responsible for payment of this claim.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize Santa Fe Imaging, LLC to release any information including information regarding diagnosis and treatment requested by the insurance company/doctor/hospital necessary to collect benefits under the policies stated at the time of treatment, or any policies which I subsequently make claim against for hospital services, including related to drug, alcohol, HIV antibody and/or psychiatric treatment and/or testing.

_____ _____

Signature of Patient or Person Representative, for *Date*