ABQ INTEGRATIVE FAMILY MEDICINE

(Please print clearly)

Last Name: _____ First Name:_____
Middle Initial: _____ Male __ Female __ Date of birth _____
Soc Sec Number: _____

Address: _____
City: _____ State: _____ Zip: _____
Mailing Address (if different) : _____
_____

Phone: _____Cell: _____ Work: _____

Email: _____
Employer: _____

Marital Status: Married___ Divorced __Widowed ___Single____ Domestic Partner ____

Primary Insurance Cardholder:
Last Name: _____ First Name _____MI ____

M____ F ____ Cellphone: _____ SSN: _____

Date of Birth: _____ Employer: _____

Emergency Contact _____Phone_____

Relationship: _____

Please present your insurance card to the receptionist at check in. Your co-payment is due at time of service. I certify that the information above is correct. I request that ABQ Integrative Family Medicine file claims on my behalf to the insurance company (companies) listed above for any services furnished to me now, and in the future, ABQ Integrative Family Medicine to release the insurance company and its agents any information needed to determine those benefits payable for the related services. Non-Medicare insurance: I acknowledge that I am personally responsible for any portion of the bill not paid for by my insurance. I understand it is my responsibility to resolve any disputes with my insurance company. Medicare: I request that payment of authorized Medicare benefits be made on my behalf to ABQ Integrative family medicine for any services provided to me. If ABQ Family Medicine believes that Medicare would not pay for any part or all the requested service, I will be asked to sign an advanced beneficiary notice signifying that I understand Medicare may not pay and that I am personally responsible for the charges. I have agreed to be responsible for any portion of the deductibles and co-pays not covered by Medicare or other insurance.

Signature: _____Date: _____

ABQ Integrative Family Medicine

Patient _____ Date of birth_____

Medication Allergies/ Sensitivities and reaction:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medications:

	Name	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____