ABQ INTEGRATIVE FAMILY MEDICINE

Experienced Concierge Care In Albuquerque

(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):_____

City: _____ State: _____ Zip: _____

Phone:_____ Cell: _____ Work: _____

Email: _____

Employer: _____

Marital Status: Married: _____   Divorced: _____   Widowed: ____   Single: ____   Domestic Partner:_____

Primary Insurance Cardholder:

Last Name: _____ First Name: _____ MI: _____

Male: _____   Female: _____   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: _____

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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. _____

04/2024