Athos G. Colón, M.D., P.A.

Patient Information **Date:** ________/_________/______

Patient Name:____DOB____ /____ /______ Sex: M / F

Address: _______________________________________ City:_______________ State:____Zip:_______

Phone: (____)______-______ Cell / Home/ work Phone: (____)_____-______ Cell / Home/ work

Social Security ______-______-______ **Race/Ethinicity:**____

Preferred language:__________________________ Email address:___________________________________

Parent/Guardian Information

Name*:* ____DOB ___ /____ /______ Relationship___________

Address: ____ City:_______________ State:____Zip:_______

Phone: (____)_____-______ Cell / Home/ work Social Security ______-______-______

Name: ____DOB ____ /____ /______ Relationship___________

Address: ____ City:_______________ State:____Zip:_______

Phone: (____)_____-______ Cell / Home/ work Social Security ______-______-______

Emergency Contact

Name: ____ Relationship to patient: ________________

Phone:(____)____-______ Cell / Home/ work

Insurance Information: If you have more than one insurance you ***must*** provide them at time of visit.

☐ Commercial / other _______________________ ID#___________________ Group#_____________

Policy holder:_______________________________SS#_______________________DOB:_____________

Policy holder's relationship to patient:____

☐ Medicaid – ID # ___________________ Firstcare / Superior /Amerigroup/Traditional

☐ Chip – ID # ________________________ Firstcare / Superior / Molina

☐ NM Medicaid – ID # ______________________ Molina / Lovelace / Presbyterian / Blue Salud

☐ Private pay (payment plans available)

Referring Doctor :____ Phone Number: (____)____-________

Reason for Referral: ____

Patient Name: ___________________________________

Birth Weight _______ lbs/kg **Birth Length**_______inch/cm

Gestational age: ☐ Full-term ☐ Preterm-If preterm # of weeks____ ☐ Post-term

Type of Delivery: ☐ Vaginal ☐ C-section

Initial feeding of baby: ☐ Nursing-how long?____ ☐ Formula

During Pregnancy were any of the following involved?

- Smoking - How often? _______
- Alcohol - How often? ________
- Recreational Drugs
- Medications-Please list ____

Were there any complications during pregnancy and/or nursery stay?

____
____
____

Hospitalization or Serious/Unusual Illnesses:

____
____

Does the patient have any Allergies:

- Food ____
- Medications ____
- Other ____

Please list all current medications (including over the counter):

____
____

Sports/extra-curricular activities the patient is involved in:

____
____

Does the patient have any disabilities? If so please list

____
____

Which Pharmacy do you prefer? ____

Family History

Illnesses - Please check below if the patient or any members of the patients family have any of the following illnesses or conditions

Patient	Family		Patient	Family	
☐	☐	Frequent ear infections	☐	☐	Kidney / bladder problems or infections
☐	☐	Frequent colds / sore throat	☐	☐	Seizures / convulsions
☐	☐	Croup	☐	☐	Heart disease/Heart attack
☐	☐	Cystic fibrosis	☐	☐	High blood pressure
☐	☐	Wheezing / asthma	☐	☐	High cholesterol
☐	☐	Pneumonia	☐	☐	Lung disease / tuberculosis
☐	☐	Eye problems	☐	☐	Stroke
☐	☐	Dental problems	☐	☐	Alcohol / drug abuse
☐	☐	Hearing problems	☐	☐	Emotional disorders / suicide attempt
☐	☐	Hay fever	☐	☐	Cancer
☐	☐	Eczema / skin problems	☐	☐	Unexplained sudden death
☐	☐	Anemia / blood problems	☐	☐	Passing out / fainting
☐	☐	Diabetes	☐	☐	Other illnesses ________________________

General Health: **Health problems –please specify whom, if any**

Mother ____

Father ____

Brothers ____

Sisters ____

Has any of the patients siblings passed away? ☐ No ☐ Yes - Explain____________________________

____

Is Patient Adopted? ☐ No ☐ Yes Does Patient know? ☐ No ☐ Yes

If yes, is there any information you know regarding birth parents health history please explain:

____

____

Athos G. Colon, M.D., P.A.

We will file the insurance for office visits and services provided by Dr. Colon. Co–pays and deductibles are due at the time of each visit. We will provide you with a receipt suitable for maintaining your records.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. I hereby authorize Athos Colon, M.D. to release any and all medical information pertinent to, (patient's name) _______________________________ case to any insurance company(s), attorney or adjustor involved with my case in order to process claims for reimbursement for services rendered by Athos Colon, MD.
2. I hereby authorize and assign direct payment to my physician of any sum I now or hereafter owe to the facility by my insurance company(s) obligated to reimburse me for the charges for services or otherwise obligated to make payment to me, or my physician based in whole, or in part upon the charges made for services. If my insurance policy prohibits direct payment to you, I hereby instruct said company(s) to make the check payable to my physician(s). I further instruct my insurance company to mail said check directly to provider. I understand that this assignment of benefits covers any treatment rendered to the above mentioned patient by the physician(s).

3. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. The signature on this document authorizes release of any information to the insurer or agency shown on the patient information form. The patient is responsible for the deductible and amounts non-covered by their insurance company(s).

______________________ ____

Date Print Patient's Name

______________________ ____

Witness Responsible Party's Signature

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Guardian

____
Print name of Patient or Guardian

____
Date

____
Relationship to Patient