XRANM
Breast Surgery Associates at Santa Fe
435 St. Michael's Drive Suite A104 Santa Fe, NM 87505
General Information: (505) 372-1052 Fax: (505) 820-3172

Breast Surgery Associates of New Mexico
101 Hospital Loop NE, Suite 106 Albuquerque, NM 87109 General Information: (505) 828-0404 Fax: (505) 323-4331

PCP:_____Phone:_____GYN:_____phone:_____
Other Doctors_____
_____
_____
_____

Patient full name: _____DOB:_____
Age:_____Sex: _____ Marital status _____SS#_____Email:_____
Address: _____City: _____ State: _____ Zip:_____
Home Phone: _____ Cell phone: _____Work Phone:_____
Employer (required): _____ Address: _____
Spouse Name: _____ DOB: _____ SS#_____
Phone#_____ Employer (required)_____Work Phone_____
Address: _____
Emergency contact: _____Phone_____
How will you pay for today's services: ____ self-pay (due at time of service)_____ insurance_____ other_____

Person financially responsible for this account if other than patient:

Name: _____DOB: _____ SS#_____
Phone #_____ Primary Insurance:_____
Phone # (on card): _____Address (on card) _____
City/State: _____Zip: _____
ID#:_____Group#_____
Policy holder:_____DOB:_____Employer(required):_____
Secondary Insurance:_____ Phone # (on card): _____
Address (on card) _____City/State: _____Zip: _____
ID#:_____ Group#_____
Policy holder:_____ DOB:_____Employer(required):_____

I authorize XRANM to perform diagnostic procedures and treatment as may be necessary for proper medical care.

FINANCIAL AGREEMENT AND INFORMATION RELEASE

I hereby assign all medical and/or surgical benefits, to include Major Medical benefits to which I am entitled, including Medicare, and other government sponsored programs, private insurance and any other health plans. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, whether or not paid by said insurance. Further, I understand that I am responsible for payment of all reasonable collection fees and any associated legal costs incurred in the collection of any past due account balance. I hereby authorize assignee to release all information necessary to secure the payment of said benefits.

Patient/parent Guardian Signature:_____Date:_____
Date of Visit: _____ Patient Name: _____ DOB:_____

BREAST HEALTH HISTORY

Please write clearly

Reason for current visit: _____

Nature of symptoms: _____

List all Allergies (including medication allergies): _____

_____ Latex Allergy? _____

List all of your Current medications (including vitamins and herbal supplements):_____

_____

Do you smoke? _____How many packs per day? _____ How many years? _____

List all surgeries and hospitalizations you have had since your last visit? _____

_____

CURRENT MEDICAL PROBLEMS:

Do you have any of the following problems? Please check all that apply and describe.

- ☐ Bleeding problems _____
- ☐ Clotting problems _____
- ☐ Diabetes _____
- ☐ High blood pressure _____
- ☐ HIV/AIDS _____
- ☐ High Cholesterol _____
- ☐ Skin Cancer _____
- ☐ Head or Neck Cancer _____
- ☐ Thyroid problems _____
- ☐ Asthma _____
- ☐ COPD _____
- ☐ Angina _____
- ☐ CHF_____
- ☐ Ulcers _____
- ☐ Hepatitis _____
- ☐ Kidney Problems _____
- ☐ Arthritis _____
- ☐ Lupus or Connective Tissue Problems _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Depression/Anxiety/Mental illness_____
- ☐ Anesthesia problems _____
- ☐ Any others not listed _____

Signature:_____Date:_____