



201 Cedar St. SE, Suite 304
Albuquerque, NM 87106

Name:		DOB:	Gender:	SSN:
Spouse/Parent:		SSN:		
Address:				
City:		State:	Zip Code:	
Home Phone:		Cell Phone:	Email:	
Patient Insurance:		ID#:	Group#:	
Occupation:		Employer:	Work Number:	
Preferred Method of Contact:		<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> E-mail Address
		<input type="checkbox"/> Home Phone	<input type="checkbox"/> Patient Portal	<input type="checkbox"/> Home Address
Preferred Language:		<input type="checkbox"/> English	<input type="checkbox"/> Japanese	<input type="checkbox"/> Russian
		<input type="checkbox"/> French	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Spanish
		<input type="checkbox"/> Italian		
Ethnicity:		<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Not Hispanic or Latino
Race (Please check all that apply):				
<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> Aleut	<input type="checkbox"/> Eskimo	<input type="checkbox"/> Native American	
<input type="checkbox"/> Asian	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Chinese	
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Hmong	<input type="checkbox"/> Japanese	
	<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Pakistani	
	<input type="checkbox"/> Thai	<input type="checkbox"/> Vietnamese		
<input type="checkbox"/> Black or African-American	<input type="checkbox"/> African	<input type="checkbox"/> African-American		
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Fijian	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Hawaiian	
	<input type="checkbox"/> Samoan	<input type="checkbox"/> Tongan		
<input type="checkbox"/> White	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Greek	<input type="checkbox"/> Italian	
Consents:				
Does SW Gynecologic Oncology Assoc., Inc. have permission to review your prescription history? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Would you like to participate in Patient Portal (Access your health records online)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
*** If yes, please complete the "User Electronic Mail Authorization Form (My Care Plus: Patient Portal)"				
Primary Doctor:		Referring Doctor:		
Other Doctors:				
Preferred Pharmacy (Name and Location):				
Allergies:				
WOULD YOU LIKE A CHAPERONE IN THE EXAM ROOM: (CIRCLE ONE)		YES	NO	

Patient Signature: _____

Date: _____