southwest℠
women's oncology

5700 Harper Drive NE, Suite 410
Albuquerque, NM 87109

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:	☐ Cell Phone ☐ Home Phone	☐ Work Phone ☐ Patient Portal	☐ E-mail Address ☐ Home Address
Preferred Language:	☐ English ☐ French ☐ Italian	☐ Japanese ☐ Portuguese	☐ Russian ☐ Spanish
Ethnicity:	☐ Hispanic or Latino		☐ Not Hispanic or Latino
Race (Please check all that apply):			
☐ American Indian or Alaskan	☐ Aleut	☐ Eskimo	☐ Native American
☐ Asian	☐ Asian Indian ☐ Filipino ☐ Korean ☐ Thai	☐ Cambodian ☐ Hmong ☐ Laotian ☐ Vietnamese	☐ Chinese ☐ Japanese ☐ Pakistani
☐ Black or African-American	☐ African	☐ African-American	
☐ Native Hawaiian or other Pacific Islander	☐ Fijian ☐ Samoan	☐ Guamanian ☐ Tongan	☐ Hawaiian
☐ White	☐ Caucasian	☐ Greek	☐ Italian

Consents:
Does SW Gynecologic Oncology Assoc., Inc. have permission to review your prescription history? ☐ Yes ☐ No
Would you like to participate in Patient Portal (Access your health records online)? ☐ Yes ☐ 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:** _____