Rehabilitation Partners LLC

Primary Care

Welcome to Rehabilitation Partners (Rehab Partners) .

Rehabilitation Partners has now opened a primary care clinic at 501 14th Street, NW Albuquerque, NM 87104. (The corner of 14th and Lomas.)

- We make healthcare simple.

- If you ever have a medical emergency, **please CALL 911**.

- For Non-Emergent medical matters, please call our office at **(505)-503-8806** to schedule an appointment and depending on the issue we will do our best to schedule the visit as soon as possible.

- **Please know that we are not an Urgent Care service.**

    - Office Hours vary at this time; please leave message and we will try to get back to you within a 24 hour turn around.

We have a few providers that see patients, they are:

- Angela Baumeister, PA-C
- Debra Green, CNP
- Mark Gould, PA-C
- Ben Lohr, PA-C
- Dr. Bette Allen – Medical Director

Please fill in the requested information below this will help us manager your care and then we will then schedule your appointment with a provider.

Rehabilitations Partners - Primary Care

The more information we have about our patients the better care we can provide.

Patient Name:_____ **DOB:**_____

Physical Address:_____ **SSN:**_____

City:_____ State:_____ Zip:_____ **Gender:**_____

Home Phone:_____ Cell:_____ Email: _____

Preferred Method of Communication: □ Home Phone □ Cell Phone □ Email □ Mail

Preferred Language: _____ **Marital Status:** _____

Ethnicity (Choose one or more):

□ American Indian or Alaska Native
□ Black or African American
□ White
□ Hispanic or Latino
□ Native Hawaiian or other Pacific Islander
□ Prefer Not To Answer
□ Asian

Preferred Pharmacy: Phone: _____ Fax:_____

Address: _____

Insurance Information: *(Please include copies of insurance cards, if available)*

Primary:_____ Name of Policy Holder: _____

Member ID: _____ Group #_____

_____

Secondary:_____ Name of Policy Holder: _____

Member ID: _____ Group #_____

Emergency Contact:_____ Relationship:_____

Phone:_____ Email:_____

Address:_____

City:_____ State:_____ Zip: _____

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible to our patients. Feel free to use additional pages to write any information not included here that you think is important.

1. Current/ Past Medical/Behavior Problems: Example; Strokes, Heart trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye Problems, etc.

Current or Past Medical Problem	Approximate Date of Onset or Diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

Past Surgeries: Example; Gall Bladder removed, Appendectomy, Hysterectomy, Cataract surgery, Prostate surgery, Heart Surgery, Angioplasty, Colonoscopy, etc.

Past Surgery	Approximate Date of Surgery
1.	
2.	
3.	
4.	
5.	

2. Recent Hospitalizations: Please list the reason for any recent hospitalizations during the past 2 years and the name of the hospital you were admitted to.

Reason for Hospitalization	Name of Hospital	Date
1.		
2.		
3.		
4.		
5.		

3. Allergies and Reaction: Example; rash, swelling, trouble breathing, etc.

☐ No Known Allergies

Allergic To	Reaction
1.	
2.	
3.	
4.	

4. List of medications

Medications.	Dosages
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

5. Family History: Please list medical problems of close family members (example; Dementia, Cancer and what type, Heart Disease, Stroke, Diabetes, Hypertension, Depression, etc.), if anyone has died, the age of death and the cause of death.

Underneath "Mother" list any brother(s)/sister(s) and their medical problems.

Family Member	Age Died	Cause of Death or any Medical Problems
Father		
Mother		
Brother		
Sister		

6. Social History:

- **Tobacco Use:** Never □ Quit □ Current User □

  Packs per day on average:_____ Years Smoked:_____

  Quit Date:_____Type: Cigarette □ Cigar □ Pipe □ Chew □

  Would you like information about quitting tobacco? Yes □ No □

- **Alcohol Use:** Never □ Quit □ Current User □

  Number of drinks per week: _____

Was drinking too much alcohol ever a problem for you? Yes □ No□

- **Illegal Drug Use:** No □ Yes □ Type_____
- **Sexual Activity:** Not Currently □ No □ Yes □
- **Describe who cares for patient:**_____
- **Tell us something the patient is proud of in their lifetime:**_____
  _____
  _____
  _____
- **Past Occupation:**_____
- **Years of Education**: _____
- **Does your religion/faith affect your healthcare decisions?** Yes □ No □

7. Advanced Directives:

Does the patient have a Durable Power of Attorney for Healthcare? Yes □ No □

Name and Relationship:_____

Does the patient have a Living Will? Yes □ No □

Does the patient have a Do Not Resuscitate Form? Yes □ No □

If you answered yes to any of the above questions, please provide us with a copy for the patient's chart.

8. Dietary Restrictions: _____

9. Activities of Daily Living: Please mark the appropriate box below.

Activities of Daily Living	No Assistance	Total Assistance	Partial Assistance: Please Describe
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			

10. Immunizations: Please mark the appropriate box below and list dates if known. If unknown, please contact your primary care doctor before our visit and ask if you are up-to-date on your immunizations.

Immunization	Yes	Date	No	Unknown	Refuses
Influenza (Flu)					
Pneumococcal (Pneumonia)					

11. Durable Medical Equipment: Please list any medical equipment you have in the home such as a bedside commode, wheel chair, walker, hospital bed, tube feeding pump, suction machine, etc. Please also list the name of the medical supplier and their phone number.

Name of Equipment	Supplier Name	Supplier Phone #
1.		
2.		
3.		
4.		
5.		

12. Care Team:

Home Health Agency: Yes No

Agency Name:_____ Phone #:_____

Physical Therapy: Yes

Agency Name:_____ Phone #:_____

Occupational Therapy: Yes

Agency Name:_____ Phone #:_____

Speech Therapy: Yes No

Agency Name:_____ Phone #:_____

13. Recent Doctors: Please list any recent doctors, their specialties (e.g. Primary doctor, cardiologist, neurologist, etc.), their phone number and fax number.

Doctor Name	Specialty	Phone	Fax
1.			
2.			
3.			