Alamo Women's Clinic of Albuquerque
10151 Montgomery Blvd NE
Albuquerque, NM 87111

PATIENT INFORMATION

(Please print clearly)
All information **must** be correct and complete.

PATIENT NAME: _____
First Name Middle Initial Last Name
DATE OF BIRTH: _____ AGE: _____ SS#: _____
DRIVER'S LICENSE OR ID#: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
*PHONE: _____ May we leave a message? YES / NO *In the instance we may need to reach you.
COUNTY: _____ RACE: _____
MARITAL STATUS: ___M ___S ___D ___W SPOUSE'S NAME: _____
EMPLOYER'S NAME: _____ PHONE: _____
EMERGENCY CONTACT PERSON: _____
EMERGENCY CONTACT PHONE: _____RELATIONSHIP: _____

PAYMENT ARRANGEMENT: (READ CAREFULLY)
Payment is expected in full amount before services are rendered. ONLY CASH, VISA, MASTERCARD AND DISCOVER CARDS ACCEPTED.

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION:
I fully comprehend the privacy notice given to me by Alamo Women's Clinic of Albuquerque I understand I must complete a medical release form in order to receive copies of my medical records or in order to have any of my medical information released to any person or facility. There is a fee for the release of medical records. I authorize Alamo Women's Clinic of Albuquerque to contact and give information about my medical condition in the event of an emergency and/or to the emergency contact person listed above.

WE RESERVE THE RIGHT TO REFUSE SERVICES:

To any person requesting an abortion who does not have the appropriate identification, is unaccompanied by a driver on the day of the abortion procedure or on any day on which sedation is administered, is under the influence of alcohol, illegal drugs and / or prescription medication(s) which in any manner may alter the patient's ability to make an informed consent, or any abusive behavior.

The nursing staff has reviewed with me, in the event I need to seek medical attention after I have left the facility; I will contact the on-call nurse and proceed to the hospital closest to my residence.

Hospital: _____ Phone: _____

Patient Signature: _____ Date: _____