Welcome to Desert Bloom Family Medicine!

We treat patients from birth through end of life.

Desert Bloom provider's consist of a team of physicians, nurse practitioners and physicians assistants. You may make an appointment with any of the providers: Dr. Christopher Hiler, M.D., Leslie Rach, FNP-C, David Seiter, FNP-C, Christine Rocks-Lopez, FNP-C, Ivette Apodaca, PA-C, or Shelby Wilson, PA-C.

Office hours are Monday through Friday, 8-12 p.m. and 1-5 p.m.(we do not accept phone calls during the noon hour.) We accept walk-ins for patients with acute medical problems only. Due to our desire to provide excellent and consistent patient care, walk-ins will **NOT** be seen for medication refills, lab reviews, or chronic medical conditions. **Walk-ins are seen on a first come basis with the first available provider.**

WALK-IN POLICY

As a courtesy to our patients, and when time permits, we do offer walk-in appointments. However, the time allotted for these appointments is minimal therefore walk-in appointments are not for chronic medical problems, it is for acute problems only. Chronic medical conditions that do **NOT** qualify for walk-in appointments are things like your diabetic follow up, hypertension follow up, pain management issues. Especially medication refills are **NOT** walk-in appointments. During peak seasons such as back to school, cold and flu season we may elect to not offer walk-in appointments. **It is always best to call the office ahead of time.** By signing this form, you agree to comply with our policy.

Please Print Patients Name:_____ **Date of Birth**_____

HIPAA Privacy Acknowledgement

I have received the Notice Of Privacy Practices and I have been provided an opportunity to review it. I authorize Desert Bloom Family Medicine to speak to the following person/persons regarding my medical conditions/needs:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

TELEPHONE COMMUNICATION AUTHORIZATION

I authorize Desert Bloom Family Medicine to contact me and leave messages at the following numbers:

Home:_____

Cellular:_____

Work:_____

Name of Patient:_____ Date of Birth_____

Signature:_____ Today's Date:_____

PATIENT INFORMATION

NAME:	DATE OF BIRTH:
ADDRESS:	SOCIAL SECURITY#:
CITY,STATE,ZIP:	PREFERRED LANGUAGE:
HOME:	MARITAL STATUS: M S D W
MOBILE:	EMAIL ADDRESS:
WORK:	PRIMARY CARE PHYSICIAN:

ETHNICITY:	HISPANIC/LATINO	NON HISPANIC/ LATINO	OTHER
RACE:	AMERICAN INDIAN OR ALASKA NATIVE	ASIAN	BLACK OR AFRICAN AMERICAN
	NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	WHITE OR CAUCASIAN	
	OTHER OR UNDETERMINED		

PATIENT EMPLOYMENT INFORMATION

EMPLOYED	RETIRED
UMPLOYED	OTHER

EMPLOYER'S NAME:	EMERGENCY CONTACTS
EMPLOYER'S PHONE:	NAME:
OCCUPATION:	RELATIONSHIP PHONE:

RESPONSIBLE PARTY(If patient is under 18years of age)

NAME:	
ADDRESS:	
CITY,STATE,ZIP:	
EMPLOYER:	
HOME PHONE:	WORK:
SS#:	DATE OF BIRTH:

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME:	INSURANCE COMPANY NAME:
ID#:	ID#:
GROUP/POLICY#:	GROUP/POLICY #:
SUBSCRIBER'S NAME:	SUBSCRIBER'S NAME:
SUBSCRIBER'S PHONE:	SUBSCRIBER'S PHONE:
RELATIONSHIP TO PATIENTI	RELATIONSHIP TO PATIENT:
SUBSCRIBER'S EMPLOYER:	SUBSCRIBER'S EMPLOYER:
SUBSCRIBERS SS#:	SUBSCRIBER'S SS#:
SUBSCRIBERS'S DATE OF BIRTH:	SUBSCRIBER'S DATE OF BIRTH:

ACKNOWLEDGEMENT OF ABUSE FREE ZONE

AT DESERT BLOOM FAMILY MEDICINE IT IS OUR BELIEF THAT OUR STAFF SHOULD BE TREATED AS YOU WOULD LIKE TO BE TREATED. FOUL LANGUAGE OR THREATENING BEHAVIOR AGAINST OUR STAFF WILL NOT BE TOLERATED AN MAY RESULTS IN DISCHARGE FROM OUR PRACTICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information i have given her is correct and best to my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. I understand that I am responsible for any amount not paid for by my insurance.

PATIENT/ GUARDIAN SIGNATURE

DATE