Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The physician you selected will review your health history and conduct an initial evaluation to determine whether the practice will accept you as a patient.

To our patients:

In order to provide you with our full time and attention when you come for an appointment, we would like to ask you to be aware of the following guidelines.

Prescription Refills:
- We are implementing a new state of the art e-prescribing system. This works best if you call your pharmacy directly for any prescription refills, even if you have no refills left. The pharmacy will contact us directly to get approval for a refill or new prescription.
- Please plan ahead as most local pharmacies request 2-3 business days to process prescription requests. Pharmacies will typically give you a 2-3 day supply of any non-narcotic medication if you run out without realizing it and you need time for the pharmacy to process the refill.
- For mail order prescriptions, please contact your pharmacy via their 800 number or website. Please be sure to contact your mail order pharmacy at least two weeks before you will need the refill. If it is necessary for us to complete forms for your mail order pharmacy, please give us three business days to complete the paperwork.
- Many drug plans will not cover brand name medications, or do so at a much higher cost. We are not always able to obtain prior authorizations for your medications. Generally, you can expect to receive generic medications or pay a higher cost if you prefer the brand name drugs.

Walk-in appointments:
- We almost always have same day appointments available for urgent needs. Please call ahead to schedule an appointment instead of arriving at our office and requesting to see the physician. Walk-ins impact our ability to see scheduled patients on time.

Test results:
- We will notify you regarding all lab results either at your appointment or by phone or mail.
- If you have not been contacted with your results two weeks after your appointment, please call our office to follow up.
- Pathology reports, pap smears, and bone density results may take up to four weeks. Please call our office if you have not been contacted after four weeks.
- Please note that if you request lab work prior to your annual appointment, your insurance may not pay for those labs.
- We are happy to provide you with your most recent lab or radiology reports. Please call ahead and we can have that ready for you at the front desk for pick up or mail results to you.

www.SOInternal.com  A Rogue Valley Physicians, PC Clinic
2900 Doctors Park Drive, Medford OR 97504  Phone:541-282-2200
Revised: 9.2014
Copies of your medical record:
- If you would like a copy of your complete medical record, we will need a formal request from you, which must be completed in writing and signed by you or your authorized representative.
- Please allow **30 days for medical record requests**. There is a processing charge to release records to yourself. There is no charge to release records from one doctor to another.

Co-pays:
- Our contracts with the insurance companies require us to collect your co-payment prior to your seeing the physicians. Please be prepared to pay this when you arrive for your appointment.

Diagnostic testing:
- Your physician will generally have the report from any diagnostic testing 2 – 3 days following your test. The radiologist who reads the study will notify your physician if there are abnormal results that require immediate follow-up.
- Most CT scans require insurance pre-authorization if not emergent exam.
- MRI, PET, Nuclear Medicine, sleep studies, cardiac studies, and other diagnostic tests require insurance pre-authorization. You will be referred to outside facilities for these studies. We contact the imaging facility of your choice and the will contact you to schedule an appointment. If you have not been contacted after two weeks, please call our office to request assistance in getting your exam scheduled.

We appreciate you choosing Southern Oregon Internal Medicine for your health care needs.
Please fill in the following information completely (Please Print)

**PATIENT INFORMATION:**

NAME ________________________________________________
LAST  FIRST  MIDDLE     NICKNAME ______________________________

HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME: [ ] YES [ ] NO
IF YES, UNDER WHAT NAME? __________________________________________

SOCIAL SECURITY # __________-________-___________   DATE OF BIRTH _____/_____/_______   GENDER ___________

PHYSICAL ADDRESS ___________________________________________________________
STREET ADDRESS   CITY   STATE   ZIP

MAILING ADDRESS
IF DIFFERENT THAN ABOVE
PO BOX   CITY   STATE   ZIP

RACE: ___________________  LANGUAGE __________________________  HISPANIC OR LATINO [ ] YES [ ] NO

MARITAL STATUS (CIRCLE ONE)        SINGLE        MARRIED          DIVORCED         LEGALLY SEPARATED         LIFE PARTNER           WIDOWED

HOME PHONE ________________________  EMAIL ___________________________  CELL PHONE ________________________

EMPLOYED: [ ] YES [ ] NO
EMPLOYER ____________________________________________  WORK PHONE __________________________

**SPOUSE INFORMATION:**

NAME ________________________________________________
LAST  FIRST  MIDDLE

DATE OF BIRTH _____/_____/_______   SOCIAL SECURITY # __________-________-___________

EMPLOYER ____________________________________________  WORK PHONE __________________________

INSURANCE INFORMATION -- PLEASE PRESENT CURRENT INSURANCE IDENTIFICATION CARD(S) TO RECEPTIONIST.

**PRIMARY COVERAGE:**

HEALTH INSURANCE: ____________________________________________
Policy # __________________  Group # __________

POLICY HOLDER’S NAME ____________________________________________  DOB _____/_____/_______  SEX __________

EMPLOYER ____________________________________________  RELATIONSHIP TO PATIENT __________________________

**SECONDARY COVERAGE:**

HEALTH INSURANCE: ____________________________________________
Policy # __________________  Group # __________

POLICY HOLDER’S NAME ____________________________________________  DOB _____/_____/_______  SEX __________

EMPLOYER ____________________________________________  RELATIONSHIP TO PATIENT __________________________

**MEDICAL TREATMENT RESULTING FROM AN ACCIDENT** (Please Complete Accident Report)

I AM RECEIVING MEDICAL TREATMENT AS A RESULT OF AN ACCIDENT: [ ] YES [ ] NO
IF YES, WHAT TYPE OF ACCIDENT? [ ] MOTOR VEHICLE [ ] WORK ACCIDENT [ ] OTHER __________________________

**INFORMATION FOR PHYSICIAN:**

EMERGENCY CONTACT: ____________________________________________  PHONE: __________________________  RELATIONSHIP: __________________________

WHO IS YOUR PRIMARY CARE PHYSICIAN? ____________________________________________  PHONE # __________________________  FAX# __________________________

HOW DID YOU HEAR OF OUR CLINIC? ____________________________________________

IF SELF-REFERRED, HOW DID YOU CHOOSE US: [ ] OUR WEBSITE [ ] PHONE BOOK [ ] OTHER __________________________

Revised 09/16/2014
NEW PATIENT QUESTIONNAIRE

TODAY'S DATE: __________________________

PATIENT NAME: ____________________________ DOB: ________________

PATIENT PHONE NO: ____________________________

INSURANCE: ____________________________

How did patient hear about us? ____________________________________________________

Who was previous doctor? ___________________________________________________

Will records release be signed? ___________________________________________________

Reason patient wants to see us: ____________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

MEDICATIONS: ____________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

DOCTOR'S RESPONSE:

NEW PATIENT TYPE:

___ CPX

___ GYN

___ 15 MIN

___ 30 MIN

___ OTHER
**HISTORY AND PHYSICAL QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

**NAME ________________________________  DATE OF BIRTH _____________________**

**CHIEF COMPLAINT __________________________________________________________________**

**ALLERGIES TO DRUGS OR X-RAY DYES:**

- ________________________________  Tetanus Inj. ________________
- ________________________________  Pneumonia vaccine ________________
- ________________________________  Mammogram ________________
- ________________________________  Pap smear ________________
- ________________________________  Colonoscopy ________________

**DATE OF LAST:**

- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________

**OTHER _________________________________________________________________**

**CURRENT MEDICATIONS:**

- ________________________________  ________________________________
- ________________________________  ________________________________
- ________________________________  ________________________________

**CURRENT CHRONIC ILLNESSES: (Such as diabetes or high blood pressure)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee/Tea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OCCUPATION:**

**HABITS:**

<table>
<thead>
<tr>
<th>Type</th>
<th>Amount</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hard drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee/Tea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOSPITALIZATIONS:**

(Surgery or illness)  

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PAST HISTORY (Check all that apply)**

- Diabetes
- High blood pressure
- Thyroid disease/goiter
- Cancer or leukemia
- Blood disease or anemia
- Arthritis
- Skin disease
- Hives
- Rashes
- Bronchitis
- Venereal disease
- Alcoholism
- Heart disease
- Hepatitis
- Lung disease
- Asthma
- Pneumonia
- Emphysema
- Tuberculosis
- Other serious illness: __________________

**Stomach disease/ulcer**

**Gallbladder disease**

**Kidney disease/stones**

**Bladder problems**

**Phlebitis/blood clots**

**Concussion**

**Seizures**

**Psychiatric problems**

**Anxiety/depression**

**FAMILY HISTORY**

- Diabetes
- Heart disease
- Tuberculosis
- Epilepsy
- High blood pressure
- Asthma
- Cancer

Page 1
HISTORY AND PHYSICAL QUESTIONNAIRE

SYSTEMS REVIEW  Please check all symptoms that currently apply.

<table>
<thead>
<tr>
<th>General:</th>
<th>Skin:</th>
<th>Urinary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too hot or cold</td>
<td>Rashes or sores</td>
<td>Frequency or urgency</td>
</tr>
<tr>
<td>Poor appetite</td>
<td>Change in mole</td>
<td>Burning or pain</td>
</tr>
<tr>
<td>Always tired</td>
<td>Lumps or swelling</td>
<td>Trouble starting</td>
</tr>
<tr>
<td>Trouble sleeping</td>
<td>Bleed or bruise easily</td>
<td>Wet pants or bed</td>
</tr>
<tr>
<td>Lack of exercise</td>
<td>Itching</td>
<td>Dark or bloody urine</td>
</tr>
<tr>
<td>Always thirsty</td>
<td></td>
<td>Nighttime urination</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurological:</th>
<th></th>
<th>Male Genital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizures</td>
<td></td>
<td>Lumps on testicles</td>
</tr>
<tr>
<td>Numbness</td>
<td></td>
<td>Painful testicles</td>
</tr>
<tr>
<td>Trembling</td>
<td></td>
<td>Prostate trouble</td>
</tr>
<tr>
<td>Fainting spells</td>
<td></td>
<td>Discharge</td>
</tr>
<tr>
<td>Change in handwriting</td>
<td></td>
<td>Burning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Head and Neck:</th>
<th>Cardiovascular:</th>
<th>Female Genital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent headaches</td>
<td>Chest pains</td>
<td>Irregular periods</td>
</tr>
<tr>
<td>Neck pains</td>
<td>Dizziness</td>
<td>Abnormal bleeding</td>
</tr>
<tr>
<td>Lumps or swelling</td>
<td>Racing heart</td>
<td>Vaginal discharge</td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td>Shortness of breath</td>
<td>Itching or odor</td>
</tr>
<tr>
<td>Frequent headaches</td>
<td>Swollen ankles</td>
<td>Severe cramping</td>
</tr>
<tr>
<td>Neck pains</td>
<td>Leg cramps</td>
<td>Hot flashes</td>
</tr>
<tr>
<td>Lumps or swelling</td>
<td>Irregular pulse</td>
<td>Menopause</td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td>Poor circulation</td>
<td>Lumps in breast</td>
</tr>
<tr>
<td>Frequent headaches</td>
<td></td>
<td>Had a C-section</td>
</tr>
<tr>
<td>Neck pains</td>
<td></td>
<td>Had abortion</td>
</tr>
<tr>
<td>Lumps or swelling</td>
<td></td>
<td># of pregnancies</td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td></td>
<td># living children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory:</th>
<th>Digestive:</th>
<th>Musculoskeletal:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheezing</td>
<td>Frequent indigestion</td>
<td>Joint pain</td>
</tr>
<tr>
<td>Frequent cough</td>
<td>Frequent belching</td>
<td>Swollen joints</td>
</tr>
<tr>
<td>Cough up phlegm or blood</td>
<td>Nausea or vomiting</td>
<td>Aching muscles</td>
</tr>
<tr>
<td>Sit up to sleep</td>
<td></td>
<td>Weakness</td>
</tr>
<tr>
<td>Trouble breathing</td>
<td></td>
<td>Tingling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mouth:</th>
<th></th>
<th>Nose:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation or diarrhea</td>
<td>Black or gray stools</td>
<td>Frequent nosebleeds</td>
</tr>
<tr>
<td>Frequent indigestion</td>
<td>Rectal pain or bleeding</td>
<td>Sinus problems</td>
</tr>
<tr>
<td>Frequent sores</td>
<td>Change in stools</td>
<td>Congestion</td>
</tr>
<tr>
<td>Swelling or lumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoarse voice or sore throat</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Financial Policy

Patient Name: ___________________________  Date of Birth: ___________________________

Thank you for choosing Southern Oregon Internal Medicine for your health care needs. The following is a statement of our Financial Policy which we require you to read and sign prior to your visit with us. Please be sure to complete both pages.

REGARDING YOUR INSURANCE

It is not possible for a medical practice to become familiar with the details of every health insurance plan it encounters. It is the responsibility of the patient to be aware of what is covered and what is not covered by your insurance, and how much the patient responsibility for services will be. We will submit insurance claims as a courtesy to our patients with insurance, and will help you in every way possible to obtain your maximum insurance benefits. However, you are responsible for our charges. We ask that you pay any deductible, co-pay and balance owed at the time of service. Please remember that we can only estimate the amount to be paid by an insurance company as they make payments based on their fee schedule. Their fee schedules may differ from our charges. While we attempt to help you in every way possible to obtain your maximum allowable insurance benefits, the insurance contract is between you and your insurance company and does not replace your responsibility for your account. If your insurance company has not paid your claim within 45 days, we will ask you to pay the balance in full. We will not be calling your insurance prior to your visit to verify your coverage.

SECONDARY INSURANCE

Having more than one insurer does not necessarily mean that your services are covered at 100%. We may bill your secondary carrier as a courtesy. You are responsible for any balance after insurance(s) has cleared.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

Continued...
FOR PATIENTS WITHOUT INSURANCE

We ask that our patients that do not have insurance pay at least ½ of their charges at the time of service. The remainder of this balance must be paid in 2 equal monthly payments. Special arrangements may be made with the advance approval of the billing department. Please let the receptionist know if you need to speak to our billing staff.

OREGON HEALTH PLAN PATIENTS

If you are an Oregon Health Plan/Medical Card patient, we require that you show your current medical card before each visit and that you are currently assigned to the appropriate physician. We will re-schedule your appointment if you fail to comply with this policy and do not present with your current card. We are unable to call your insurance prior to your visit to verify your coverage.

SERVICE CHARGES

A fee of $25.00 will be assessed to your account for any check returned due to non-sufficient funds. A fee of $20.00 may be assessed to your account for a missed appointment.

WE ACCEPT PERSONAL CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CASH

Thank you for your attention to our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the terms of this Policy. In addition, I authorize Southern Oregon Internal Medicine to release any medical information necessary to process a claim. I hereby assign payment directly to Rogue Valley Physicians, PC all payments due from my insurance company. I understand that I am financially responsible for the charges and should it become necessary to collect monies in court, all court costs and attorney fees are the responsibility of the patient.

____________________________________
Patient (or Legal Guardian) Signature     Date
Authorization to Release Medical Information

Patient: ___________________________ Date of Birth: __________________________

I consent to the release of Medical Information (records):

To: ___________________________ From: (Physician, Clinic, or Person)
(Include phone and/or Fax #)

Fernando Cendejas, M.D  
2900 Doctors Park Drive  
Medford, OR 97504  
Phone: (541) 282-2223  
Fax: (541) 282-2265

Information to be released:

____ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, X-ray & Laboratory Reports. From Date: __________ To Date: __________

____ X-ray reports only. Date(s): __________

____ Laboratory and Pathology reports only. Date(s): __________

____ Other tests or studies (list type of test/study and date performed): __________

____ Other (specify): __________

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record. * (Initial if release is authorized)

____ Drug and alcohol abuse

____ Information related to diagnosis/treatment of HIV.

Please note that a separate release is required for Behavioral Health Information.

Purpose of Disclosure:

___________________________________________________________________________________

___________________________________________________________________________________

This authorization is valid for six months after the date of signature. The authorization may be revoked any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

Signature of patient or legally authorized representative  Date
Telephone Disclosure form

Patient Name (please print)___________________________ DOB: __________

Welcome to Southern Oregon Internal Medicine. We want to be sure we handle your personal medical information in a way that is acceptable to you. We appreciate your taking the time to fill out this form. If you have a special request, be sure to let your receptionist know.

It is okay to leave information on my answering machine: _____ Yes _____ No

Please indicate which medical information you authorize to be disclosed via the telephone from our office:

_____ Appointments   _____ Pathology Results
_____ Lab Results   _____ Prescription/Samples Information
_____ EKG Results   _____ Mammogram Results (men may also need this…)
_____ X-Ray Results   _____ ALL OF THE ABOVE

It is okay to disclose my personal health information to the following the following individuals:

_____ Spouse (Name): __________________________________________

_____ Significant Other (Name): __________________________________

_____ Family Members or Friends (Names): __________________________________

___________________________________________________________

___________________________________________________________

_____ Caretaker (Name): _________________________________________

_____ Do not disclose my health information to anyone

__________________________________________  _______________
Patient Signature                      Date

Thank you. If you need to get in touch with our office, remember that we may be busy serving other patients, but will make every effort to return calls from you within 24 business hours.