



Southern Oregon Internal Medicine
Rogue Valley Physicians, P.C.

2900 Doctors Park Drive, Suite 200
Medford, OR 97504
Phone: (541) 282-2200
Business Fax: (541) 282-2237

Please fill in the following information completely: (Please Print)

1) PATIENT INFORMATION:

Date: _____
 Maiden name: _____

Name: _____
 Date of birth: _____
 If minor child, parent(s) name: _____
 Mailing address: _____ Home Phone: _____
 City: _____ State: _____ Zip: _____
 Married Widowed Divorced Separated Single
 Employer: _____ Phone: _____
 Insurance: _____ Group No.: _____
 Social Security number: _____

2) RESPONSIBLE PARTY: If same as # 1, check box

Person responsible for paying bill: _____
 Relationship to above person: Spouse Mother Father Other: _____
 Address: _____
 Employer: _____ Phone: _____
 Insurance: _____ Group No.: _____
 Social Security number: _____

3) SPOUSE INFORMATION: If same as # 2, check box

Spouse's name: _____
 Employer: _____ Phone: _____
 Insurance: _____ Group No.: _____
 Social Security number: _____

4) INFORMATION FOR PHYSICIAN:

Friend/neighbor who can be reached in case of emergency: _____
 Person or doctor who referred you to this clinic: _____
 If self-referred, how did you choose us: Newspaper Phone Book Other: _____

AUTHORIZATION TO PAY-RELEASE MEDICAL INFORMATION

I hereby authorize Southern Oregon Internal Medicine the release of any medical information necessary to process a claim. I hereby assign payment directly to Southern Oregon Internal Medicine 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. A service charge of 1.5% will be assessed on accounts past due.

Patient Signature: _____ Date: _____
 (Parent or responsible party, if patient is minor child)

NOTE: We bill secondary insurance companies with which we contract. If you have questions regarding insurance, please speak with our office manager or one of our insurance specialists.

To control billing costs, we request that co-pays, deductables, and non-covered services be paid at the time of service. Please indicate how you wish to pay for today's services:

METHOD OF PAYMENT: Cash Check Visa Mastercard Medicaid/OHP
If Medicaid (open card), show your card to the receptionist at each visit.



HEALTH HISTORY QUESTIONNAIRE

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

Name (Last, First, M.I.):	Date of birth:
	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Previous or referring doctor:	Date of Last physical exam:
Other doctors you see:	How did you hear about us?

PERSONAL HEALTH HISTORY

Cardiac Stress Test Date: <input type="checkbox"/> <i>Have not had test</i>	DXA/Bone Density Date: <input type="checkbox"/> <i>Have not had test</i>
Flu shot this season? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date:	Pneumonia vaccination date:
List any medical problems that other doctors have diagnosed. <i>(Check common health problems from the list below or fill in as needed.)</i>	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Ulcers	
Other:	
Surgeries	
Year	Reason
	Hospital
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	

List your prescribed drugs and over-the-counter drugs and/or nutritional supplements

Medication Name	Strength	Frequency Taken

Allergies to medications

Name of Drug	Reaction You Had

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL
AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	<input type="checkbox"/> Sedentary (no exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 mins)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 mins or more)			
Diet	Are you following a diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which one			
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		How many drinks per week?	
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes pks/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	# of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other health habits not covered in questions above:				

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F				
	<input type="checkbox"/> M <input type="checkbox"/> F				

EDUCATION AND OCCUPATION

Where were you born? City:	State:
What is your highest level of education?	
What is your employment status? (What was your last job?)	
List some of your favorite hobbies:	

WOMEN ONLY

Age at onset of menstruation:	
Date of last menstruation:	Number of days of cycle:
Number of pregnancies:	Are you pregnant or breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last pap smear:	Normal/abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Last mammogram:	Normal/abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No

MEN ONLY

Date of last prostate and rectal exam:
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OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Signature

Date



Southern Oregon Internal Medicine FINANCIAL POLICY

Thank you for choosing Southern Oregon Internal Medicine for your health care needs. The following is a statement of our Financial Policy which we request that you to read and sign prior to your visit with us.

REGARDING YOUR INSURANCE

It is not possible for a medical practice to become familiar with the details for every health insurance plan it encounters as there are over 6,000 registered insurance companies and plans. Therefore, it is your responsibility as the patient or legally responsible adult to know your benefits, what is covered, what is excluded and how much will be the patient responsibility. We will submit insurance claims as a courtesy to our patients with insurance. However, you are responsible for our charges.

We are required by law and/or insurance company policy requirements 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.

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.

PRIVATE PAY

We ask that our patients without insurance pay a minimum of ½ of their charges at the time of service. The remainder of this balance must be paid in 3 equal monthly payments. Special arrangements can be made with the advance approval of the clinic manager or billing department.

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MEDICAID/OHP PATIENTS

Oregon Health Plan/Medical Card patients, this office requires 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 the current card.

SERVICE CHARGES

We reserve the right to apply a finance charge in the amount of 1.5% per month or 18% annually to all account balances after 90 days as allowed by state law. 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, DISCOVER AND CASH

Thank you for understanding 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:

Patient Name

Date

Signature of Guardian

Date

Relationship

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