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 responsibile 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.

Southern Oregon Internal Medicine
Rogue Valley Physicians, P.C.
Robert N. Blanche, M.D.

2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2226
Fax: (541) 282-2266

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:

_____
_____
_____

OTHER _____

DATE OF LAST:

Tetanus Inj. _____
Pneumonia vaccine _____
Mammogram _____
Pap smear _____
Colonoscopy _____

CURRENT MEDICATIONS:

_____ _____
_____ _____
_____ _____

OCCUPATION: _____

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

_____
_____
_____
_____

HABITS:

Type:	Amount	Frequency
Tobacco	_____	_____
Alcohol	_____	_____
Marijuana	_____	_____
Hard drugs	_____	_____
Coffee/Tea	_____	_____
Other	_____	_____

HOSPITALIZATIONS:

(Surgery or illness)	Date	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST HISTORY *(Check all that apply)*

_____ Diabetes	_____ Venereal disease	_____ Stomach disease/ulcer
_____ High blood pressure	_____ Alcoholism	_____ Gallbladder disease
_____ Thyroid disease/goiter	_____ Heart disease	_____ Kidney disease/stones
_____ Cancer or leukemia	_____ Hepatitis	_____ Bladder problems
_____ Blood disease or anemia	_____ Lung disease	_____ Phlebitis/blood clots
_____ Arthritis	_____ Asthma	_____ Concussion
_____ Skin disease	_____ Pneumonia	_____ Seizures
_____ Hives	_____ Emphysema	_____ Psychiatric problems
_____ Rashes	_____ Tuberculosis	_____ Anxiety/depression
_____ Bronchitis	Other serious illness: _____	

FAMILY HISTORY

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

HISTORY AND PHYSICAL QUESTIONNAIRE

SYSTEMS REVIEW Please check all symptoms that currently apply.

General:
__ Too hot or cold
__ Poor appetite
__ Always tired
__ Trouble sleeping
__ Lack of exercise
__ Always thirsty
__ Crying spells
__ Depressed
__ Anxiety or stress
__ Hopeless outlook
__ Lose temper often
__ Considered suicide
__ Weight loss or gain
__ Sexual difficulty

Head and Neck:
__ Frequent headaches
__ Neck pains
__ Lumps or swelling
__ Difficulty swallowing

Eyes:
__ Blurred vision
__ Seeing double or halos
__ Eye pain
__ Watering or itching
__ Wear eyeglasses
Date of last eye exam:
_____

Ears:
__ Difficulty hearing
__ Hearing aides
__ Buzzing or ringing
__ Earaches or drainage
__ Frequent infections

Mouth:
__ Dental problems
__ Frequent sores
__ Swelling or lumps
__ Hoarse voice or sore throat

Skin:
__ Rashes or sores
__ Change in mole
__ Lumps or swelling
__ Bleed or bruise easily
__ Itching

Neurological:
__ Seizures
__ Numbness
__ Tingling
__ Trembling
__ Fainting spells
__ Change in handwriting

Cardiovascular:
__ Chest pains
__ Dizziness
__ Racing heart
__ Shortness of breath
__ Swollen ankles
__ Leg cramps
__ Irregular pulse
__ Poor circulation

Respiratory:
__ Wheezing
__ Frequent cough
__ Cough up phlegm or blood
__ Sit up to sleep
__ Trouble breathing

Digestive:
__ Frequent indigestion
__ Frequent belching
__ Nausea or vomiting
__ Spit up blood
__ Constipation or diarrhea
__ Black or gray stools
__ Rectal pain or bleeding
__ Change in stools

Urinary:
__ Frequency or urgency
__ Burning or pain
__ Trouble starting
__ Wet pants or bed
__ Dark or bloody urine
__ Nighttime urination

Male Genital:
__ Lumps on testicles
__ Painful testicles
__ Prostate trouble
__ Discharge
__ Burning

Female Genital:
__ Irregular periods
__ Abnormal bleeding
__ Vaginal discharge
__ Itching or odor
__ Severe cramping
__ Hot flashes
__ Menopause
__ Lumps in breast
__ Had a C-section
__ Had abortion
__ # of pregnancies
__ # living children
Date last period:_____
Date last pap: _____

Musculoskeletal:
__ Joint pain
__ Swollen joints
__ Aching muscles
__ Weakness
__ Tingling
__ Handicapped

Nose:
__ Frequent nosebleeds
__ Sinus problems
__ Congestion

Comments:

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.

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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A Rogue Valley Physicians, PC clinic | www.roguevalleyphysicians.com