



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.

Fernando Cendejas, M.D.
Southern Oregon Internal Medicine
2900 Doctors Park Drive
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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



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 Fernando Cendejas, MD

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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

Date	Hospital
_____	_____
_____	_____
_____	_____

PAST HISTORY *(Check all that apply)*

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

FAMILY HISTORY

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	Page 1

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
 - Watery 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

Comments:

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



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

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