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.

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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.)*:	❑ **M** ❑ **F** **DOB:**
Marital Status: ❑ **Single** ❑ **Partnered** ❑ **Married** ❑ **Separated**	❑ **Divorced** ❑ **Widowed**
Previous or referring doctor:	**Date of Last physical exam:**
Other doctors you see:	**How did you hear about us?**

PERSONAL HEALTH HISTORY

Childhood Illnesses: ❑ **Measles** ❑ **Mumps** ❑ **Rubella** ❑ **Chickenpox** ❑ **Rheumatic Fever** ❑ **Polio**

Immunizations & Dates	❑ **Tetanus**	❑ **Pneumonia**
	❑ **Hepatitis B**	❑ **Chickenpox**
	❑ **Hepatitis A**	❑ **MMR**
	❑ **Zostavax** *Shingles*	❑ **Other**
Health Maintenance *These are tests that are recommended for screening and early identification of common chronic health problems.*	**Colonoscopy Date:** ❑ *Have not had test*	**Cardiac Stress Test Date:** ❑ *Have not had test*
	Triple Vessel Screening Date: *(ultrasound aorta, carotid & legs)* ❑ *Have not had test*	**Bone Density Date:** ❑ *Have not had test*

List any medical problems that other doctors have diagnosed *(you can circle common problems on the first line)*

Diabetes Hypertension High-Cholesterol Osteoporosis Heart-disease Thyroid-disease Asthma Lung-Disease Anemia
Blackouts Bronchitis Cancer Gout Kidney-disease Kidney-stones Osteoarthritis Rheumatoid-Arthritis Seizures Ulcers

Surgeries

Year	**Reason**	**Hospital**

Have you ever had a blood transfusion? ❑ **Yes** ❑ **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 AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL						
Exercise	❑ Sedentary (No exercise)					
	❑ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	❑ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)					
	❑ Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 minutes)					
Diet	Are you following a diet? If so, which one				❑ Yes	❑ No
	# of meals you eat in an average day?					
	Rank salt Intake	❑ Hi	❑ Medium	❑ Low		
	Rank fat intake	❑ Hi	❑ Medium	❑ Low		
Caffeine	❑ None	❑ Coffee	❑ Tea	❑ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				❑ Yes	❑ No
	If yes, what kind?		How many drinks per week?			
	Are you concerned about the amount you drink?				❑ Yes	❑ No
	Have you considered stopping?				❑ Yes	❑ No
	Have you ever experienced blackouts?				❑ Yes	❑ No
	Are you prone to “binge” drinking?				❑ Yes	❑ No
	Do you drive after drinking?				❑ Yes	❑ No
Tobacco	Do you use tobacco?				❑ Yes	❑ No
	❑ Cigarettes pks/day	❑ Chew - #/day	❑ Pipe - #/day	❑ Cigars - #/day		
	# of years	❑ Or year quit				
Drugs	Do you currently use recreational or street drugs?				❑ Yes	❑ No
	Have you ever given yourself street drugs with a needle?				❑ Yes	❑ No
Sex	Are you sexually active?				❑ Yes	❑ No
	If yes, are you trying for a pregnancy?				❑ Yes	❑ No
	If not trying for a pregnancy, list contraceptive method.					
	Any discomfort with intercourse?				❑ Yes	❑ No
	Do you have any concerns regarding sexual health you would like to discuss?				❑ Yes	❑ No

Personal Safety	**Do you live alone?**	❑ **Yes**	❑ **No**
	Do you have frequent falls?	❑ **Yes**	❑ **No**
	Do you have vision or hearing loss?	❑ **Yes**	❑ **No**
	Do you have an Advance Directive or Living Will?	❑ **Yes**	❑ **No**
	Would you like information on the preparation of these?	❑ **Yes**	❑ **No**
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	❑ **Yes**	❑ **No**
	Do you wear seatbelts when driving or riding in a car?	❑ **Yes**	❑ **No**
	Have you ever had your driving license suspended?	❑ **Yes**	❑ **No**

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	❑ M ❑ F	
Mother				❑ M ❑ F	
Sibling	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F			❑ M ❑ F	
	❑ M ❑ F		Grandmother *Maternal*		
	❑ M ❑ F		Grandfather *Maternal*		
	❑ M ❑ F		Grandmother *Paternal*		
	❑ M ❑ F		Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for y ou?	❑ **Yes**	❑ **No**
Do you feel depressed?	❑ **Yes**	❑ **No**
Do you feel helpless or hopeless?	❑ **Yes**	❑ **No**
Do you panic when stressed?	❑ **Yes**	❑ **No**
Do you have problems with eating or your appetite?	❑ **Yes**	❑ **No**
Do you cry frequently?	❑ **Yes**	❑ **No**
Have you ever attempted suicide?	❑ **Yes**	❑ **No**
Have you ever seriously thought about hurting yourself?	❑ **Yes**	❑ **No**
Do you have trouble sleeping?	❑ **Yes**	❑ **No**
Have you ever been to a counselor?	❑ **Yes**	❑ **No**
Have you often been bothered by feeling down, depressed or hopeless?	❑ **Yes**	❑ **No**
Have you often been bothered by little interest or pleasure in doing things?	❑ **Yes**	❑ **No**

EDUCATION AND OCCUPATION

Where were you born?
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:** **Period every _____days**		
Number of pregnancies _____ Number of live births _____		
Heavy periods, irregularity, spotting, pain or discharge?	❑ Yes	❑ No
Are you pregnant or breastfeeding?	❑ Yes	❑ No
Have you had a D&C, Hysterectomy or Cesarean?	❑ Yes	❑ No
Any urinary tract, bladder or kidney infections within the last year?	❑ Yes	❑ No
Any blood in your urine?	❑ Yes	❑ No
Any problems with control of urination?	❑ Yes	❑ No
Any hot flashes or sweating at night?	❑ Yes	❑ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period?	❑ Yes	❑ No
Have you experienced any recent breast tenderness, lumps or nipple discharge?	❑ Yes	❑ No
Date of your last pap and rectal exam.		
Have you ever had an abnormal pap? *If yes, when*: _____		
Date of your last mammogram.		
Have you ever had an abnormal mammogram?		

MEN ONLY

Do you usually get up to urinate during the night? *If yes, # of times:* _____	❑ Yes	❑ No
Any blood in your urine?	❑ Yes	❑ No
Do you feel burning discharge from penis?	❑ Yes	❑ No
Has the force of your urination decreased?	❑ Yes	❑ No
Have you had any kidney, bladder or prostate infections within the last 12 months?	❑ Yes	❑ No
Do you have any problems emptying your bladder completely?	❑ Yes	❑ No
Any difficulty with erection or ejaculation?		
Any testicle pain or swelling?		
Date of last prostate and rectal exam.		

OTHER PROBLEMS

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

❑ Skin	❑ Chest/Heart	❑ Recent changes in:
❑ Head/Neck	❑ Back	❑ Weight
❑ Ears	❑ Intestinal	❑ Energy level
❑ Nose	❑ Bladder	❑ Ability to sleep
❑ Throat	❑ Bowel	❑ Other pain/discomfort
❑ Lungs	❑ 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.

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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