Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

NAME		DOB:	
ADDRESS			
CITY/ZIP	IS ARIZONA YOUR PERMANENT RESIDENCE: YES/NO		
SECONDARY ADDRESS (if applicable)			
ADDRESS			
CITY/ZIP			
SOCIAL SECURITY		MARITAL STATUS	

CONTACT

HOME	
CELL	
WORK	
OTHER	
EMAIL	

PREFERRED METHOD OF CONTACT

OK TO LEAVE MESSAGE? YES/ NO

☐ HOME	☐ CELL	☐ WORK	☐ OTHER	☐ EMAIL

ARE YOU CURRENTLY WORKING? YES/NO	DISABLED? YES/NO	RETIRED? YES/NO
IS YOUR SPOUSE CURRENTLY WORKING? YES/NO		

EMPLOYMENT INFORMATION

THE FOLLOWING IS FOR	THE PATIENT/ THE PERSON RESPONSIBLE FOR PAYMENT
EMPLOYER NAME	
EMPLOYER PHONE	
EMPLOYER ADDRESS	
CITY/ZIP	

RESPONSIBLE PARTY

OTHER THAN PATIENT

NAME		RELATIONSHIP		PHONE	
ADDRESS					

PRIMARY CARE PHYSICIAN		PHONE	
REFERRING PHYSICIAN		PHONE	

Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

INSURANCE INFORMATION

PRIMARY INSURANCE		PHONE	
INSURED NAME		DOB	
GROUP #		POLICY #	
SECONDARY INSURANCE		PHONE	
INSURED INAME		DOB	
GROUP #		POLICY #	

PATIENT SIGNATURE/RESPONSIBLE PARTY: **DATE:**

Name: _____ Date: _____ ACC #: _____
For office use only.

Ironwood Physicians, PC

PATIENT HISTORY FORM

Reason for Consultation: _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

PAST MEDICAL HISTORY

Please check if you've been diagnosed with any of the following conditions:

☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Lupus
☐ Arthritis	☐ Emphysema / COPD	☐ High Cholesterol	☐ Migraines
☐ Asthma / Allergies	☐ Enlarged Prostate	☐ Hepatitis	☐ Osteoporosis
☐ Bleeding Disorder	☐ Glaucoma	☐ HIV/AIDS	☐ Psychological Disorders
☐ Blood Clots	☐ Heart Disease	☐ Irregular Heart Rhythm	☐ Seizures
☐ Chronic Kidney Disease	☐ Heart Failure	☐ Liver Disease	☐ Stroke / TIA

Other Medical Conditions *(Please List)*:

☐ **Cancer** *(type)*: | ***Previous Treatment?***

Are you currently participating in a clinical trial? Yes ☐ No ☐

Please Provide Dates for:

Last Mammogram:	**Last Colonoscopy:**	**Last Dexa Scan:**	**Last Flu Vaccine:**

SURGICAL HISTORY

Please list any surgeries that you have had and (approximate) date & facility below

_____

_____

SOCIAL HISTORY

Please answer all of the questions below

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____ Religious Preference: _____

Have you ever used tobacco? ☐ Yes ☐ No ☐ Current Use ☐ Past Use [Quit ____ years ago]

If so, which type(s)? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chewing Tobacco

How much per day? _____ For how many years? _____

Do you consume alcohol? ☐ Yes ☐ No If so, what type(s)? _____

How often? ☐ Daily ☐Weekly ☐ Socially Number of Drinks/week: _____

Do you use any recreational drugs? ☐ Yes ☐ No

REPRODUCTIVE HISTORY

For female patients only

Age at first period? _____ Number of pregnancies? _____ Number of births? _____ Age at 1st birth? _____

Have you gone through menopause? ☐ Yes ☐ No If yes, at what age? _____

Have you ever taken oral contraceptive pills? ☐ Yes ☐ No When: _____

Have you ever taken hormone replacement therapy? ☐ Yes ☐ No When: _____

Name: _____ Date: _____ ACC #: _____

For office use only.

Have you ever taken any medications for treatment of infertility? ☐ Yes ☐ No When? _____

Have you had a tubal ligation: ☐ Yes ☐ No When? _____

Is your flow ☐ Regular or ☐ Irregular How often? _____ How long? _____

How many pads/tampons do you use in a day? _____ Any pain, bleeding or blood clots? ☐ Yes ☐ No

Have you ever had a breast biopsy before? ☐ Yes ☐ No How many have you had? _____

If Yes, were any abnormal? ☐ Yes ☐ No Explain: _____

FAMILY HISTORY

Please indicate any medical problems. If deceased, indicate age and cause of death

Mother:	☐Living	☐Deceased	Age:	Cause of Death:
Father:	☐Living	☐Deceased	Age:	Cause of Death:
Other:	☐Living	☐Deceased	Age:	Cause of Death:

Other Significant Health Conditions: Adopted: ☐

SYSTEM REVIEW

Please check if you are experiencing any of the following symptoms:

GENERAL:
- ☐ Yes / ☐ No Chills
- ☐ Yes / ☐ No Fever
- ☐ Yes / ☐ No Fatigue
- ☐ Yes / ☐ No Generalized Weakness
- ☐ Yes / ☐ No Night Sweats
- ☐ Yes / ☐ No Trouble Sleeping
- ☐ Yes / ☐ No Weight Gain
- ☐ Yes / ☐ No Weight Loss

SKIN:
- ☐ Yes / ☐ No Bruising
- ☐ Yes / ☐ No Itching
- ☐ Yes / ☐ No Lesions/Boils
- ☐ Yes / ☐ No Nail Changes
- ☐ Yes / ☐ No Rashes
- ☐ Yes / ☐ No Sores

HEAD / NECK:
- ☐ Yes / ☐ No Discharge from Ears
- ☐ Yes / ☐ No Dry Mouth
- ☐ Yes / ☐ No Frequent Sore Throats
- ☐ Yes / ☐ No Hearing loss
- ☐ Yes / ☐ No Hoarseness
- ☐ Yes / ☐ No Nose Bleeds
- ☐ Yes / ☐ No Ringing/Pain in ears
- ☐ Yes / ☐ No Sores/Ulcers in mouth
- ☐ Yes / ☐ No Vision Changes

BREASTS:
- ☐ Yes / ☐ No Lumps / Masses
- ☐ Yes / ☐ No Nipple Discharge
- ☐ Yes / ☐ No Pain
- ☐ Yes / ☐ No Skin Changes

HEART / LUNG:
- ☐ Yes / ☐ No Murmur
- ☐ Yes / ☐ No Pain in Legs
- ☐ Yes / ☐ No Palpitations
- ☐ Yes / ☐ No Swollen Ankles
- ☐ Yes / ☐ No Cough
- ☐ Yes / ☐ No Coughing Blood
- ☐ Yes / ☐ No Shortness of Breath
- ☐ Yes / ☐ No Sputum/Mucus
- ☐ Yes / ☐ No Wheezing

ENDOCRINE / LYMPHATIC:
- ☐ Yes / ☐ No Cold Intolerance
- ☐ Yes / ☐ No Excessive Hunger
- ☐ Yes / ☐ No Excessive Sweating
- ☐ Yes / ☐ No Excessive Thirst
- ☐ Yes / ☐ No Heat Intolerance
- ☐ Yes / ☐ No Hot Flashes
- ☐ Yes / ☐ No Joint/Bone Pain
- ☐ Yes / ☐ No Painful Lymph Nodes
- ☐ Yes / ☐ No Swollen Lymph Nodes
- ☐ Yes / ☐ No Sexual Dysfunction

KIDNEYS / BLADDER:
- ☐ Yes / ☐ No Blood in Urine
- ☐ Yes / ☐ No Cloudy Urine
- ☐ Yes / ☐ No Frequency of Urination
- ☐ Yes / ☐ No Getting up at Night
- ☐ Yes / ☐ No Hesitancy of Urination
- ☐ Yes / ☐ No Incontinence
- ☐ Yes / ☐ No Leakage/Retention
- ☐ Yes / ☐ No Pain when Urinating
- ☐ Yes / ☐ No Passed Stones
- ☐ Yes / ☐ No Urgency of Urination

GASTROINTESTINAL:
- ☐ Yes / ☐ No Black/Tarry/Clay Stools
- ☐ Yes / ☐ No Bloating
- ☐ Yes / ☐ No Constipation
- ☐ Yes / ☐ No Diarrhea
- ☐ Yes / ☐ No Difficulty Swallowing
- ☐ Yes / ☐ No Heartburn
- ☐ Yes / ☐ No Hemorrhoids
- ☐ Yes / ☐ No Nausea
- ☐ Yes / ☐ No Painful Swallowing
- ☐ Yes / ☐ No Poor Appetite
- ☐ Yes / ☐ No Rectal Bleeding
- ☐ Yes / ☐ No Vomiting
- ☐ Yes / ☐ No Vomiting Blood
- ☐ Yes / ☐ No Yellowing of Skin/Eyes

MUSCULOSKELETAL:
- ☐ Yes / ☐ No Back Pain
- ☐ Yes / ☐ No History of Fractures

NEUROLOGIC:
- ☐ Yes / ☐ No Balance Problems
- ☐ Yes / ☐ No Dizziness
- ☐ Yes / ☐ No Fainting
- ☐ Yes / ☐ No Headaches
- ☐ Yes / ☐ No Numbness/Tingling
- ☐ Yes / ☐ No Seizures
- ☐ Yes / ☐ No Tremors

PSYCHOLOGIC:
- ☐ Yes / ☐ No Anxiety
- ☐ Yes / ☐ No Depression
- ☐ Yes / ☐ No Memory Changes
- ☐ Yes / ☐ No Nervousness

Name: _____ Date: _____ _____

Medication and Allergy List

ALLERGIES

Please list all known allergies and reactions below

Allergy	*Reaction*

Allergy	*Reaction*

Are you allergic to Iodine? ☐ Yes ☐ No

If you have no known allergies, please circle: **NO ALLERGIES**

MEDICATIONS

Please list all medications
(including prescription, over-the-counter, and supplements)

Medication Name	*Dose*	*Frequency*	*Taken for*	*Date Started*	*Date Ended*
Preferred Pharmacy					
Mail-In Pharmacy					

ADVANCED DIRECTIVES

Do you have a Living Will?	☐ Yes ☐ No
Do you have a durable power of attorney?	☐ Yes ☐ No
Do you have a DNR?	☐ Yes ☐ No

Last Updated 11/16/2017

Ironwood Physicians, PC

Consent to Release Protected Health Information
Contact List

Patient Name: _____ DOB: _____ Date: _____

Initials ☐	**I authorize Ironwood Physicians, PC to use/disclose my personal health information to the individuals listed on this form.**
Initials ☐	I understand that Ironwood Physicians, PC staff may leave detailed messages on my voicemail.

1. Contact Name: ***(Emergency Contact)***			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (Describe) _____ ☐Friend ☐Other (Describe) _____			
2. Contact Name			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (Describe) _____ ☐Friend ☐Other (Describe) _____			
3. Contact Name:			
Phone:		*Phone (other):*	
Address:			
Relationship: ☐Spouse ☐Family (Describe) _____ ☐Friend ☐Other (Describe) _____			

I hereby authorize Ironwood Physicians, PC to use and disclose my personal health information to the individuals identified on this form.
I understand this authorization does not expire unless written notice is mailed to P.O. Box 6423 Chandler AZ, 85246.

I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist.

I understand that the individuals identified on this form will be treated by Ironwood Physicians PC as individuals involved directly in my care and as such, Ironwood Physicians, PC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.

I understand that I have a right to request and receive a Notice of Privacy Practices from Ironwood Physicians, PC.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Ironwood Physicians PC will not be affected if I refuse to sign this authorization.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Relationship to Patient: _____

Ironwood Physicians, PC

FINANCIAL POLICY/ASSIGNMENT OF BENEFITS FOR PATIENTS

- I understand that I have medical insurance which when billed on my behalf should pay for their portion of my office visits and treatment charges. _____ initials

- I will inform Ironwood Physicians, PC or Ironwood Cancer and Research Centers of a change in my insurance coverage, if I fail to provide changes to my insurance I will be liable for services rendered but not covered. _____ initials

- I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract. _____ initials

- I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company. _____ initials

- I understand that I will leave my credit card information to be kept on file and that if I do not pay within **60 days** after my insurance has paid, I acknowledge that Ironwood Physicians, PC and Ironwood Cancer and Research Centers will charge the balance to the credit card on file. _____ initials

- I understand that if for any reason my insurance company does not pay for the covered services within **90 days** of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on file. _____ initials

- I thereby assign all medical benefits directly to Ironwood Physicians, PC and Ironwood Cancer and Research Centers for services rendered at their facilities. _____ initials

- I understand if a CT or PET/CT scan is completed it will be necessary for a licensed Radiologist to interpret or read your scan results. You will be receiving two statements for your CT or PET/CT scan for their professional interpretation of the CT or PET/CT scan separate of Ironwood. _____ initials

- We may request proof of insurance premium payment. _____ initials

- I have read and received a copy, if desired, of this document. _____ initials

Patient Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Ironwood Cancer & Research Centers

Outsmarting Cancer One Patient at a Time™

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

- *Treatment.* Your health information may be used by staff members or disclosed to other healthcare professionals for the purposes of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

- *Payment.* Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

- *Healthcare Operations.* Your health information may be disclosed as necessary to support the day-to-day activities and management of **Ironwood Physicians PC.** For example, information on the services you received may be used to support the budgeting and financial reporting, and activities to evaluate and promote quality.

- *Law Enforcement.* Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

- *Public Health Reporting.* Your health information may be disclosed to public health agencies as required by state law. For example, we are required to report certain communicable diseases to the state's public health department.

- *Research.* We conduct clinical research here. Our clinical research staff may look at your health records as part of your current care to determine if you may be eligible for any research studies being done at our facility. All patient research conducted at Ironwood Cancer & Research Centers goes through a special process required by law that reviews protections for patients involved in research, including privacy. *We will not use your health information or disclose it outside of Ironwood Cancer & Research Centers for research reasons without getting your prior written approval or determining that your privacy is protected.*

- ***Other uses and disclosures require your authorization.*** Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Ironwood Physicians, PC offices

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice of your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

Complaints/Contact Person

If you would like to submit a question, comment, or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Administrator
Ironwood Cancer & Research Centers
695 S. Dobson Rd.
Chandler, AZ. 85224

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.