Ironwood Physicians, PC

Dear Patient,

We would like to thank you for choosing Ironwood Cancer & Research Centers. We will make every effort to make your experience with us a positive one. To help expedite your appointment, please print and have the following forms fully completed prior to your arrival on your scheduled appointment day:

1. **Patient Demographic Information**
2. **Patient History Form**
3. **Medication List/Allergy List**
4. **Consent to Release Health Information Contact List (HIPAA)**
5. **Financial Policy/Assignment of Benefits**
6. **Questions for your appointment**

The following forms are for your information:

1. **Electronic Device Policy**
2. **Patient Portal Introduction**

Please also bring your insurance card, a picture ID, and please arrive 30 minutes before your scheduled appointment time for your first visit. Maps and information to all of our locations are located on our website: www.ironwoodcrc.com.

Thank You

Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

NAME		DOB:	
ADDRESS			
	IS ARIZONA YOUR PERMANENT RESIDENCE: YES/NO		
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

CURRENT/FORMER OCCUPATION	

RESPONSIBLE PARTY
OTHER THAN PATIENT

NAME		RELATIONSHIP		PHONE	
ADDRESS					

PRIMARY CARE PHYSICIAN		PHONE	
REFERRING PHYSICIAN		PHONE	

INSURANCE INFORMATION

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

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

Last Updated 6/24/2015

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

D.O.B: _____

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.

D.O.B: _____

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: _____ D.O.B: _____

Ironwood Physicians, PC

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	

Last Updated 6/24/2015

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. _____ 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 Physicians, PC

Please use the form to write down any questions that you may have prior to your visit.

- _____

  _____

  _____

- _____

  _____

  _____

- _____

  _____

  _____

- _____

  _____

  _____

- _____

  _____

  _____

- _____

Ironwood Cancer & Research Centers

Outsmarting Cancer One Patient at a Time™

Electronic Device Policy
(Smart phones, tablets, iPads, computers)

Dear Patients and visitors,

It is our commitment to create and maintain an environment that respects patients and their privacy.

We request that you refrain from taking photographs, audio and video recordings or video chat (Skype, FaceTime, etc.) in the clinical treatment areas.

Thank you for your understanding.

Sincerely,

Ironwood Cancer & Research Centers

JOIN US ONLINE

Ironwood Cancer & Research Centers

Outsmarting Cancer One Patient at a Time™

PATIENT PORTAL

Steps to Sign Up:

1. Provide the Front Desk w/ an E-mail Address
2. Check your E-mail & Click the Activation Link
3. Provide Basic Demographics & the Code from the E-mail

That's it, you're ready to use the portal!

WHY SHOULD I ACTIVATE MY PORTAL ACCOUNT?

- View Continuity of Care Documents (CCD)
- Request Appointments
- Update Address and Info
- Receive Monthly Newsletter
- Appointment Reminders (*Coming Soon*)
- Request Lab Results
- Ask Billing/Financial Questions
- Fill Out New Patient Forms
- Ask Your Doctor

For questions about the portal, please inquire at the Front Desk or give our office a call:

Chandler	Gilbert	Glendale	Mesa (Arbor)	Mesa (Dobson)	Phoenix	Scottsdale
480-821-2838	480-890-7705	623-312-3000	480-981-1326	480-969-3637	602-494-6800	480-314-6670

Visit Our Website: www.ironwoodcrc.com

Like Us On Facebook: Ironwood Cancer & Research Centers