ACCT# _____

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Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

NAME : _____ DOB: _____ MARITAL STATUS: _____

ADDRESS: _____ CITY/ZIP: _____

SOCIAL SECURITY: _____ IS ARIZONA YOUR PERMANENT RESIDENCE? Y/N

SECONDARY ADDRESS (IF APPLICABLE)

ADDRESS: _____ CITY/ZIP: _____

CONTACT INFORMATION - Check preferred method of contact

HOME: _____ ☐

CELL: _____ ☐

OTHER: _____ ☐

EMAIL: _____ ☐

OK TO LEAVE A DETAILED VOICEMAIL? Y/N

ARE YOU CURRENTLY WORKING? Y/N

DISABLED? Y/N RETIRED? Y/N

IS YOUR SPOUSE CURRENTLY WORKING? Y/N

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

RESPONSIBLE PARTY - Other than the patient

NAME: _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____ CITY/ZIP: _____

EMPLOYMENT INFORMATION Person responsible for payment

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS: _____ CITY/ZIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____ DOB: _____

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ PHONE: _____

INSURED NAME: _____ DOB: _____

POLICY #: _____ GROUP #: _____

HOW DID YOU HEAR ABOUT US? Please check the following

☐ BILLBOARD ☐ COMMERCIAL ☐ WEBSITE ☐ OTHER: _____

☐ SOCIAL MEDIA: ☐ FACEBOOK ☐ TWITTER ☐ LINKEDIN ☐ INSTAGRAM ☐ YOUTUBE ☐ PINTEREST

PATIENT SIGNATURE/RESPONSIBLE PARTY: _____ DATE: _____

Name: _____ Date: _____ ACCT #: _____

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

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:	Last Pneumonia 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

Name: _____ Date: _____ ACCT #: _____

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PATIENT HISTORY FORM

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? _____ Last Menstrual Cycle _____

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

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: _____

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

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: _____ Age: _____ Cause of Death: _____

Adopted: ☐

Other Significant Health Conditions:

_____

_____

CANCER FAMILY HISTORY

Please indicate any family cancer.

Relative:	Type of Cancer:	Age at Diagnosis:	Lineage (Maternal or Paternal side)

Please answer these additional questions if applicaple

Is there a known hereditary cancer predisposition syndrome in your family? _____

Are you aware of prior genetic testing in any of your family members with cancer? If yes, what are the results? _____

Do you have Jewish ancestry on either maternal or paternal side? _____

To be completed by patients with bleeding or clotting problems

Is there a known hereditary bleeding or clotting disorder that runs in your family? _____

Is there a family history of blood clots or bleeding disorder? _____

Name: _____ Date: _____ ACCT#: _____

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MEDICATION AND ALLERGY LIST

ALLERGIES

PLEASE LIST ALL KOWN ALLERGIES AND REACTIONS BELOW

ALLERGIES	REACTIONS

ALLERGIES	REACTIONS

Are you allergic to iodine? YES NO

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

MEDICATIONS

PLEASE LIST ALL MEDICATIONS
(INCLUDING PRECRIPTIONS OVER THE COUNTER, AND SUPPLEMENTS)

MEDICATIONS	DOSE	FREQUENCY	TAKE FOR	START DATE	STOP DATE
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

Name: _____ Date: _____ ACCT#: _____
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REVIEW OF SYSTEMS

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 Chronic Skin Condition
☐ Yes / ☐ No Itching
☐ Yes / ☐ No Lesions/Boils
☐ Yes / ☐ No Nail Changes
☐ Yes / ☐ No Rash
☐ 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

MUSCULOSKELETAL/ MOVEMENT:
☐ Yes / ☐ No Back Pain
☐ Yes / ☐ No Decreased Range of Motion
☐ Yes / ☐ No History of Fractures
☐ Yes / ☐ No Wheelchair, Cane or Walker

BREAST:
☐ Yes / ☐ No Armpit Lumps/Masses
☐ Yes / ☐ No Breast Lumps/Masses
☐ Yes / ☐ No Nipple Discharge
☐ Yes / ☐ No Pain
☐ Yes / ☐ No Skin Changes

HEART/LUNG:
☐ Yes / ☐ No Chest Pain
☐ 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 Sleep w/Head Elevated
☐ Yes / ☐ No Sputum/Mucus
☐ Yes / ☐ No Use C-PAP at home
☐ Yes / ☐ No Use Oxygen at home
☐ 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

NEUROLOGICAL:
☐ Yes / ☐ No Balance Problems
☐ Yes / ☐ No Claustrophobia
☐ Yes / ☐ No Dizziness
☐ Yes / ☐ No Fainting
☐ Yes / ☐ No Headaches
☐ Yes / ☐ No Numbness/Tingling
☐ Yes / ☐ No Seizures
☐ Yes / ☐ No Tremors

GYNECOLOGIC:
☐ Yes / ☐ No Irregular Periods
☐ Yes / ☐ No Painful Periods
☐ Yes / ☐ No Painful Intercourse
☐ Yes / ☐ No Vaginal Bleeding
☐ Yes / ☐ No Vaginal Discharge
☐ Yes / ☐ No Vaginal Dryness

KIDNEY/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 Incontinence of Stool
☐ 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

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

Acct#. _____

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Ironwood Physicians, PC

Consent to Release Protected Health Information

Name: _____ Date: _____

I authorize Ironwood Physicians, PC to use/disclose my personal health information to the individuals listed on this form.

1. Contact Name:			
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 understand this authorization does not expire unless we receive written notice.

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Relationship to Patient: _____

Acct# _____

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FINANCIAL POLICY/ASSIGNMENT OF BENEFITS

Financial Agreement:

- I understand that I am 100% responsible for all charges incurred.
- I understand and agree that it is my responsibility to pay all co-payments, deductibles and estimated co-insurance at the time services are rendered .
- 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.
- I authorize the release of medical records to process any insurance claim.
- I understand that Ironwood Physicians, PC may request proof of insurance premium payment.

Assignment of Insurance Benefits:

- I hereby assign all medical benefits directly to Ironwood Physicians, PC.

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

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. I understand that I have a right to a Notice of Privacy Practices from Ironwood Physicians, PC. Please read 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.

Request 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.