SOUTHERN OREGON INTERNAL MEDICINE

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The physician you selected will review your health history and conduct an initial evaluation to determine whether the practice will accept you as a patient.

To our patients:

In order to provide you with our full time and attention when you come for an appointment, we would like to ask you to be aware of the following guidelines.

Prescription Refills:

- We are implementing a new state of the art e-prescribing system. This works best if you **call your pharmacy directly for any prescription refills,** even if you have no refills left. The pharmacy will contact us directly to get approval for a refill or new prescription.
- Please plan ahead as most local pharmacies request **2-3 business days** to process prescription requests. Pharmacies will typically give you a 2-3 day supply of any non-narcotic medication if you run out without realizing it and you need time for the pharmacy to process the refill.
- For **mail order prescriptions, please contact your pharmacy via their 800 number or website.** Please be sure to contact your mail order pharmacy at least two weeks before you will need the refill. If it is necessary for us to complete forms for your mail order pharmacy, please give us three business days to complete the paperwork.
- Many drug plans will not cover brand name medications, or do so at a much higher cost. We are not always able to obtain prior authorizations for your medications. Generally, you can expect to receive generic medications or pay a higher cost if you prefer the brand name drugs.

Walk-in appointments:

- We almost always have same day appointments available for urgent needs. Please call ahead to schedule an appointment instead of arriving at our office and requesting to see the physician. Walk-ins impact our ability to see scheduled patients on time.

Test results:

- We will notify you regarding all lab results either at your appointment or by phone or mail.
- If you have not been contacted with your results two weeks after your appointment, please call our office to follow up.
- Pathology reports, pap smears, and bone density results may take up to four weeks. Please call our office if you have not been contacted after four weeks.
- Please note that if you request lab work prior to your annual appointment, your insurance may not pay for those labs.
- We are happy to provide you with your most recent lab or radiology reports. Please call ahead and we can have that ready for you at the front desk for pick up or mail results to you.

Copies of your medical record:

- If you would like a copy of your complete medical record, we will need a formal request from you, which must be completed in writing and signed by you or your authorized representative.
- Please allow **30 days for medical record requests.** There is a processing charge to release records to yourself. There is no charge to release records from one doctor to another.

Co-pays:

- Our contracts with the insurance companies require us to collect your co-payment prior to your seeing the physicians. Please be prepared to pay this when you arrive for your appointment.

Diagnostic testing:

- Your physician will generally have the report from any diagnostic testing 2 – 3 days following your test. The radiologist who reads the study will notify your physician if there are abnormal results that require immediate follow-up.
- Most CT scans require insurance pre-authorization if not emergent exam.
- MRI, PET, Nuclear Medicine, sleep studies, cardiac studies, and other diagnostic tests require insurance pre-authorization. You will be referred to outside facilities for these studies. We contact the imaging facility of your choice and the will contact you to schedule an appointment. If you have not been contacted after two weeks, please call our office to request assistance in getting your exam scheduled.

We appreciate you choosing Southern Oregon Internal Medicine for your health care needs.

Southern Oregon Internal Medicine
A Rogue Valley Physicians P.C. Clinic

2900 Doctors Park Drive, Suite 200
Medford, Oregon 97504
Phone: 541-282-2200
Fax: 541-282-2237

Please fill in the following information completely (Please Print)

PATIENT INFORMATION:

TODAY'S DATE _____

NAME _____ NICKNAME _____
LAST FIRST MIDDLE

HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME: [ ] YES [ ] NO

IF YES, UNDER WHAT NAME? _____

SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH _____/_____/_____ GENDER _____

PHYSICAL ADDRESS _____
STREET ADDRESS CITY STATE ZIP

MAILING ADDRESS IF DIFFERENT THAN ABOVE _____
PO BOX CITY STATE ZIP

RACE: _____ LANGUAGE _____ HISPANIC OR LATINO [ ] YES [ ] NO

MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED LEGALLY SEPARATED LIFE PARTNER WIDOWED

HOME PHONE _____ EMAIL _____ CELL PHONE _____

EMPLOYED: YES NO EMPLOYER _____ WORK PHONE _____

SPOUSE INFORMATION:

NAME _____ HOME PHONE: _____
LAST FIRST MIDDLE

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY # _____-_____-_____

EMPLOYER _____ WORK PHONE _____ OCCUPATION _____

INSURANCE INFORMATION -- PLEASE PRESENT CURRENT INSURANCE IDENTIFICATION CARD(S) TO RECEPTIONIST.

PRIMARY COVERAGE:

HEALTH INSURANCE: _____ Policy # _____ Group # _____

POLICY HOLDER'S NAME _____ DOB _____/_____/_____ SEX _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

SECONDARY COVERAGE:

HEALTH INSURANCE: _____ Policy # _____ Group # _____

POLICY HOLDER'S NAME _____ DOB _____/_____/_____ SEX _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

MEDICAL TREATMENT RESULTING FROM AN ACCIDENT (Please Complete Accident Report)

I AM RECEIVING MEDICAL TREATMENT AS A RESULT OF AN ACCIDENT: [ ] YES [ ] NO

IF YES, WHAT TYPE OF ACCIDENT? [ ] MOTOR VEHICLE [ ] WORK ACCIDENT [ ] OTHER _____

INFORMATION FOR PHYSICIAN:

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

WHO IS YOUR **PRIMARY CARE PHYSICIAN**? _____ PHONE # _____ FAX# _____

HOW DID YOU HEAR OF OUR CLINIC? _____

IF SELF-REFERRED, HOW DID YOU CHOOSE US: [ ] OUR WEBSITE [ ] PHONE BOOK [ ] OTHER _____

Southern Oregon Internal Medicine
2900 Doctors Park Drive, Suite 200 | Medford, OR 97504
Phone: (541) 282-2227 | General Fax: (541) 282-2263

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
A Rogue Valley Physicians, P.C. Clinic

Financial Policy

Patient Name:_____ Date of Birth:_____

Thank you for choosing Southern Oregon Internal Medicine for your health care needs. The following is a statement of our Financial Policy which we require you to read and sign prior to your visit with us. Please be sure to complete both pages.

REGARDING YOUR INSURANCE

It is not possible for a medical practice to become familiar with the details of every health insurance plan it encounters. It is the responsibility of the patient to be aware of what is covered and what is not covered by your insurance, and how much the patient responsibility for services will be. We will submit insurance claims as a courtesy to our patients with insurance, and will help you in every way possible to obtain your maximum insurance benefits. However, you are responsible for our charges. We ask 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. We will not be calling your insurance prior to your visit to verify your coverage.

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.

Continued...

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www.SOInternal.com A Rogue Valley Physicians, PC Clinic

FOR PATIENTS WITHOUT INSURANCE

We ask that our patients that do not have insurance pay at least ½ of their charges at the time of service. The remainder of this balance must be paid in 2 equal monthly payments. Special arrangements may be made with the advance approval of the billing department. Please let the receptionist know if you need to speak to our billing staff.

OREGON HEALTH PLAN PATIENTS

If you are an Oregon Health Plan/Medical Card patient, we require 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 your current card. We are unable to call your insurance prior to your visit to verify your coverage.

SERVICE CHARGES

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, AMERICAN EXPRESS, DISCOVER AND CASH

Thank you for your attention to 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. In addition, I authorize Southern Oregon Internal Medicine to release any medical information necessary to process a claim. I hereby assign payment directly to Rogue Valley Physicians, PC 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.

_____ _____

Patient (or Legal Guardian) Signature Date

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SOUTHERN OREGON INTERNAL MEDICINE
2900 Doctors Park Drive
Medford, OR 97504

Authorization to Release Medical Information

Patient: _____ Birth date: _____/_____/_____

I consent to the release of Medication Information (records):

To: (Physician, Clinc or Person)

Name: Julie Graham, FNP-C
Address: 2900 Doctors Park Dr. Suite 200
City/State/Zip: Medford, OR 97504
Phone: 541-282-2200
Fax: 541-282-2275

From: (Physician, Clinic, or Person)

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

****PLEASE SEND THE RECORD ON CD OR THUMB DRIVE WHEN POSSIBLE; DO NOT FAX MORE THAN 25 PAGES****

Information to be released: (initial each line that applies)

_____ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, Diagnostic & Laboratory Reports. From Date: _____ To Date: _____
_____ Diagnostic reports only. Date(s): _____
_____ Laboratory and Pathology reports only. Date(s): _____
_____ Other tests or studies (list type of test/study and date performed: _____
_____ Other (specify): _____

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record. *(Initial if release is authorized)

_____ Drug and alcohol abuse
_____ Information related to diagnosis/treatment of HIV.

Please note that a separate release of behavioral health information is required.

Purpose of Disclosure:

_____

_____

****A charge of $25.00 for the first ten (10) pages and .28 cents for each page over ten (10) may apply.**

This authorization is valid for six months after the date of signature. If the undersigned provides written notice of revocation, it may be revoked at any time (but not retroactively to a release of information made in good faith).

_____ _____

Signature of patient or legally authorized representative Date

SOUTHERN OREGON INTERNAL MEDICINE

Telephone Disclosure form

Patient Name (please print) _____ DOB _____

Welcome to Southern Oregon Internal Medicine. We want to be sure we handle your personal medical information in a way that is acceptable to you. We appreciate your taking the time to fill out this form. If you have a special request, be sure to let your receptionist know.

It is okay to leave information on my answering machine: _____ Yes _____ No

Please indicate which medical information you authorize to be disclosed via the telephone from our office:

_____ Appointments
_____ Lab/Pathology Results
_____ EKG Results
_____ X-ray Results
_____ Medical Chart Notes
_____ Prescription/Sample information
_____ Mammogram Results (men may also need this…)
_____ ALL OF THE ABOVE

Authorization for verbal disclosure of my personal health information to the following individuals:

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

_____ (initial) Do not disclose my health information to anyone.

_____ _____ _____
Signature Date Relationship

This authorization may be revoked by giving written or verbal notice to Southern Oregon Internal Medicine. Such notice will be effective immediately upon receipt by Southern Oregon Internal Medicine personnel. This consent will be valid for up to one (1) year.

Date of consent: _____ Date consent expires: _____

I recognize that the information disclosed may contain information that is protected by federal and state laws (i.e., Drug/Alcohol Abuse, Mental Health, HIV/AIDS), and I expressly consent to the disclosure of such information.
Initial each one that applies:

_____ HIV/AIDS results _____ Mental Health _____ Drug/Alcohol Abuse

_____ _____
Signature Date

Thank you. If you need to contact our office, remember that we may be busy serving other patients, but we will make every effort to return calls within 24 business hours.