Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

NAME: M ☐ F ☐ DOB:

ADDRESS:

IS ARIZONA YOUR PERMANENT RESIDENCE: YES / NO

ALT ADDRESS:

SOCIAL SECURITY: MARITAL STATUS:

CONTACT

HOME:

CELL:

WORK:

OTHER:

PREFERRED METHOD OF CONTACT

OK TO LEAVE MESSAGE? YES / NO

☐ HOME ☐ CELL ☐ WORK ☐ OTHER ☐ EMAIL

EMAIL:

ARE YOU CURRENTLY WORKING? YES / NO DISABLED? YES / NO RETIRED? YES / NO

CURRENT/FORMER OCCUPATION or EMPLOYER:

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 NAME: DOB:

GROUP # POLICY #

PATIENT SIGNATURE/RESPONSIBLE PARTY: DATE:

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, 85245.

I understand *this* may include information relating to communicable diseases, such as HIV/AJDS, sexually transmitted diseases, behavioral or mental health, 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: _____

Last Updated 6/24/2015

Ironwood Physicians
Ironwood Cancer & Research Centers
Ironwood Radiology

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Ironwood Physicians may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at PO Box 6423, Chandler, AZ 85246

With your consent, Ironwood Physicians may mail to your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Ironwood Physicians may mail to your home or office any items that assist the practice in carrying out any TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your Pill to carry out treatment, payment and healthcare operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound to our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment payment and healthcare operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Patient Name:

_____

Signature of Patient or Legal Guardian _____

Print Legal Guardian Name (If applicable)

_____

Date: _____

Urologic Health Associates

Authorization to Release Protected Health Information (PHI)
TO Urologic Health Associates
For the purpose of continuing patient care

Patient Name _____ Date of Birth _____/_____/_____

Address _____

City, State, Zip Code _____

Day time Telephone Number _____

I hereby authorize the hospital or medical facility in receipt of this form to disclose the following Protected Health Information pertaining to the above referenced patient to:

Urologic Health Associates

☐ Please release all pertinent records from the dates of _____ to _____

OR

☐ Please release the following Information:

_____

_____

I understand that this authorization covers records relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV"), behavioral, and/or mental health, alcohol and/or drug abuse treatment genetic testing, If any such records exist.

I understand that at any time I have the right to revoke on this authorization to release medical records, except If the recipient has already taken action on this authorization. I understand that in order to revoke this authorization I must do so in writing, and send my revocation to the recipient. I also understand that the revocation only applies to records that have not been released in response to the authorization.

I understand that, once this information has been disclosed to a third party, that the information may not be protected by Federal Privacy Regulations and may be re-disclosed by the third party or entity that has the received this Information. I also understand that Urologic Health Associates will not re-disclose my protected health information without my written consent.

I understand that this authorization does; and will expire one (1) year from the date of signing unless an earlier date Is specified in writing.

_____
Expiration Date

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient (If not patient)

Ironwood Physicians, PC

Ironwood Physicians Health Update

Name: _____ Date: _____

Flu Shot Yes ☐ No ☐

Date received (month/year): _____

Pneumonia Shot Yes ☐ No ☐

Date received (month/year): _____

Colorectal Cancer Screening Yes ☐ No ☐

Date of procedure (month/year): _____

Do you feel sad or depressed? Yes ☐ No ☐

PHQ-9 questionnaire complete (month/year): _____

DEXA Scan Yes ☐ No ☐

Date of Scan (month/year): _____

Mammogram Yes ☐ No ☐

Date (month/year): _____

Urinary Incontinence Yes ☐ No ☐

Date (month/year): _____

Any changes to your medical/surgical history since your last visit (for established patients)?

Yes ☐ No ☐

_____

_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 *weeks,* how often have you been bothered by any of the following problems?
(use "✓" to Indicate your answer)

	Not at all	*Not at all*	*Not at all*	*Not at all*
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4, Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems *made* It for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

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	☐ HIVIAIDS	☐ Psychological Disorders
☐ Blood Clots	☐ Heart Disease	☐ Irregular Heart Rhythm	☐ Seizures
☐ Chronic Kidney	☐ 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 I Masses
☐ Yes / ☐ No Nipple Discharge
☐ Yes / ☐ No Pain
☐ Yes / ☐ No Skin Changes

HEART / LUNG:

☐ Yes / ☐ No Murmur Pain in
☐ Yes / ☐ No 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
☐ Yes / ☐ No Stools 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: _____ _____

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	