Ironwood
Physicians, PC

Dear Patient,

We would like to thank you for choosing Southeast Valley Urology, a division of Ironwood Physicians, P.C. 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**

Please also bring your insurance card, a picture ID, and please arrive 15-30 minutes before your scheduled appointment time for your first visit.

Thank You

Ironwood Physicians, PC

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

NAME:	Male / Female	DOB:	
ADDRESS:			
Alternate 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/EMERGENCY CONTACT
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:**

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 Pneumonia Vaccine:**

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

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: ☐

_____

Signature: Relationship to patient:

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 Local Pharmacy & Cross-streets	
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 authorize Ironwood Physicians, PC staff to 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 insurance 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(s) as determined by my insurance company.** _____ 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. _____ initials

- I thereby assign all medical benefits (ie payments from the insurance) 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: _____