ACCT# ______________________

For office use only.

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

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:

Name: ____________________ Date: ____________ ACCT#: ____________

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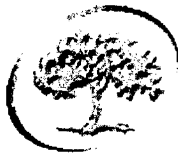


Ironwood Physicians, PC

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

Acct#. ______________

For office use only.

Ironwood
Physicians, PC

Consent to Release Protected Health Information

Name: ______________________________ Date: ____________________

<table>
<tr><td colspan="4">I authorize Ironwood Physicians, PC to use/disclose my personal health information to the individuals listed on this form.</td></tr>
<tr><td>1. Contact Name:</td><td colspan="3"></td></tr>
<tr><td>Phone:</td><td></td><td>Phone (other):</td><td></td></tr>
<tr><td>Address:</td><td colspan="3"></td></tr>
<tr><td colspan="4">Relationship: ☐Spouse ☐Family (Describe) ____________ ☐Friend ☐Other (Describe) ____________</td></tr>
<tr><td>2. Contact Name</td><td colspan="3"></td></tr>
<tr><td>Phone:</td><td></td><td>Phone (other):</td><td></td></tr>
<tr><td>Address:</td><td colspan="3"></td></tr>
<tr><td colspan="4">Relationship: ☐Spouse ☐Family (Describe) ____________ ☐Friend ☐Other (Describe) ____________</td></tr>
<tr><td>3. Contact Name:</td><td colspan="3"></td></tr>
<tr><td>Phone:</td><td></td><td>Phone (other):</td><td></td></tr>
<tr><td>Address:</td><td colspan="3"></td></tr>
<tr><td colspan="4">Relationship: ☐Spouse ☐Family (Describe) ____________ ☐Friend ☐Other (Describe) ____________</td></tr>
</table>

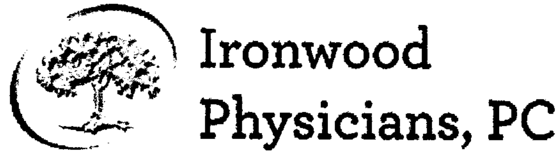
I understand this authorization does not expire unless we receive written notice.

Patient Signature: ______________________________ Date: ____________________

Personal Representative Signature: ______________________________ Date: ____________________

Relationship to Patient: ______________________________

Acct# ________________
For office use only.



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: ____________

Last Updated 01/20/2020

Ironwood
Physicians, PC

Code of Conduct for Patients and Visitors

In an effort to provide a safe and healthy environment for staff and patients, Ironwood Physicians PC expects patients, parents and accompanying family and friends to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited and may result in your immediate dismissal from the practice:

- Physical assault or threatening to inflict bodily harm.
- Rude behaviors in person or through written, verbal or electronic communication, including but not limited to the following: Profanity, harassment, offensive or intimidating statements or gestures and threats of violence.
- Racial or cultural slurs or other derogatory remarks associated with race, language, or sexual orientation.
- Requests that would constitute illegal or unethical behavior on the part of Ironwood.
- Possessing firearms or any weapon
- Making verbal threats to harm another individual or destroy property

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or are unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- Questions about your billing can be addressed with our patient accounts team @ 480-245-6285.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

I agree to the Ironwood Physicians "Code of Conduct for Patients and Visitors"

______________________________	____________________
Patient's Name	Date of Birth
______________________________	____________________
Caregiver's Name/Relationship to patient	Date