



**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 they 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.**



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 \_\_\_\_\_



## 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.):   | <input type="checkbox"/> M <input type="checkbox"/> F    DOB: |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> 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

|                                  |  |                                     |
|----------------------------------|--|-------------------------------------|
| <b>Immunizations &amp; Dates</b> | <input type="checkbox"/> Tetanus           | <input type="checkbox"/> Pneumonia  |
|                                  | <input type="checkbox"/> Hepatitis B       | <input type="checkbox"/> Chickenpox |
|                                  | <input type="checkbox"/> Hepatitis A       | <input type="checkbox"/> MMR        |
|                                  | <input type="checkbox"/> Zostavax Shingles | <input type="checkbox"/> Other      |

|  |   |  |
|--|---|--|
| <b>Health Maintenance</b><br><i>These are tests that are recommended for screening and early identification of common chronic health problems.</i> | <b>Colonoscopy Date:</b><br><input type="checkbox"/> Have not had test  | <b>Cardiac Stress Test Date:</b><br><input type="checkbox"/> Have not had test |
|  | <b>Triple Vessel Screening Date:</b><br><i>(ultrasound aorta, carotid &amp; legs)</i><br><input type="checkbox"/> Have not had test | <b>Bone Density Date:</b><br><input type="checkbox"/> 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



|                 |  |                              |                             |
|-----------------|--|------------------------------|-----------------------------|
| Personal Safety | Do you live alone?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                 | Do you have frequent falls?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                 | Do you have vision or hearing loss?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                 | Do you have an Advance Directive or Living Will?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                 | Would you like information on the preparation of these?  | <input type="checkbox"/> Yes | <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                 | Do you wear seatbelts when driving or riding in a car?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                 | Have you ever had your driving license suspended?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### FAMILY HEALTH HISTORY

|         | AGE  | SIGNIFICANT HEALTH PROBLEMS |             | AGE  | SIGNIFICANT HEALTH PROBLEMS |
|---------|--|-----------------------------|-------------|--|-----------------------------|
| Father  |  |                             | Children    | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |
| Mother  |  |                             |             | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |
| Sibling | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |             | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |
|         | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |             | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             |
|         | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             | Grandmother |  |                             |
|         | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             | Maternal    |  |                             |
|         | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             | Grandfather |  |                             |
|         | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             | Maternal    |  |                             |
|         | <input type="checkbox"/> M<br><input type="checkbox"/> F |                             | Grandmother |  |                             |
|         |  |                             | Paternal    |  |                             |
|         |  |                             | Grandfather |  |                             |
|         |  |                             | Paternal    |  |                             |

### MENTAL HEALTH

|  |                              |                             |
|--|------------------------------|-----------------------------|
| Is stress a major problem for you?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel depressed?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel helpless or hopeless?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you panic when stressed?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have problems with eating or your appetite?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you cry frequently?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever attempted suicide?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever seriously thought about hurting yourself?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble sleeping?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever been to a counselor?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you often been bothered by feeling down, depressed or hopeless?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you often been bothered by little interest or pleasure in doing things? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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?  | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Are you pregnant or breastfeeding?   | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Have you had a D&C, Hysterectomy or Cesarean?  | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Any urinary tract, bladder or kidney infections within the last year?                                    | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Any blood in your urine?   | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Any problems with control of urination?  | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Any hot flashes or sweating at night?  | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period? | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Have you experienced any recent breast tenderness, lumps or nipple discharge?                            | <input type="checkbox"/> Yes     | <input type="checkbox"/> No |
| Date of your last pap and rectal exam.   |                                  |                             |
| Have you ever had an abnormal pap? <i>If yes, when:</i> _____  |                                  |                             |
| Date of your last mammogram.   |                                  |                             |
| Have you ever had an abnormal mammogram?   |                                  |                             |

### MEN ONLY

|   |                              |                             |
|---|------------------------------|-----------------------------|
| Do you usually get up to urinate during the night? <i>If yes, # of times:</i> _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any blood in your urine?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel burning discharge from penis?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the force of your urination decreased?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had any kidney, bladder or prostate infections within the last 12 months?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any problems emptying your bladder completely?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> 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. |                                      |  |
| <input type="checkbox"/> Skin  | <input type="checkbox"/> Chest/Heart | <input type="checkbox"/> Recent changes in:    |
| <input type="checkbox"/> Head/Neck   | <input type="checkbox"/> Back        | <input type="checkbox"/> Weight                |
| <input type="checkbox"/> Ears  | <input type="checkbox"/> Intestinal  | <input type="checkbox"/> Energy level          |
| <input type="checkbox"/> Nose  | <input type="checkbox"/> Bladder     | <input type="checkbox"/> Ability to sleep      |
| <input type="checkbox"/> Throat  | <input type="checkbox"/> Bowel       | <input type="checkbox"/> Other pain/discomfort |
| <input type="checkbox"/> Lungs   | <input type="checkbox"/> 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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## **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.**

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Patient (or Legal Guardian) Signature

---

Date



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 Medical Information (records):**

**To:** \_\_\_\_\_ **From: (Physician, Clinic, or Person  
Include phone &/or fax#)** \_\_\_\_\_

**Dr. Dennis Linden**  
2900 Doctors Park Drive  
Medford, OR 97504  
Phone: (541) 282-2200  
Fax: (541) 282-2275

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*PLEASE SEND RECORDS ON CD IF POSSIBLE\*\***

**Information to be released:**

- \_\_\_\_\_ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, X-ray & Laboratory Reports. From Date: \_\_\_\_\_ To Date: \_\_\_\_\_
- \_\_\_\_\_ X-ray 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 is required for Behavioral Health Information.**

**Purpose of Disclosure:**

\_\_\_\_\_  
\_\_\_\_\_

This authorization is valid for six months after the date of signature. The authorization may be revoked any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

\_\_\_\_\_  
Signature of patient or legally authorized representative

\_\_\_\_\_  
Date



**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 Results
- \_\_\_\_\_ EKG Results
- \_\_\_\_\_ X-Ray Results
- \_\_\_\_\_ Pathology Results
- \_\_\_\_\_ Prescription/Samples Information
- \_\_\_\_\_ Mammogram Results (men may also need this...)
- \_\_\_\_\_ ALL OF THE ABOVE

**It is okay to disclose my personal health information to the following the following individuals:**

\_\_\_\_\_ Spouse (Name): \_\_\_\_\_

\_\_\_\_\_ Significant Other (Name): \_\_\_\_\_

\_\_\_\_\_ Family Members or Friends (Names): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Caretaker (Name): \_\_\_\_\_

\_\_\_\_\_ Do not disclose my health information to anyone

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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