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 <u>any</u> 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_____

Fernando Cendejas, M.D.
Southern Oregon Internal Medicine
2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2223
Fax: (541) 282-2265

NEW PATIENT QUESTIONNAIRE

TODAY'S DATE: _____

PATIENT NAME: _____ **DOB:** _____

PATIENT PHONE NO: _____

INSURANCE: _____

How did patient hear about us? _____

Who was previous doctor? _____

Will records release be signed? _____

Reason patient wants to see us: _____

_____

_____

MEDICATIONS: _____

_____

_____

DOCTOR'S RESPONSE:

NEW PATIENT TYPE:
____ **CPX**
____ **GYN**
____ **15 MIN**
____ **30 MIN**
____ **OTHER**

Southern Oregon Internal Medicine
Rogue Valley Physicians, P.C.
Fernando Cendejas, MD

2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2200
Fax: (541) 282-2265

HISTORY AND PHYSICAL QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME _____ **DATE OF BIRTH** _____

CHIEF COMPLAINT _____

ALLERGIES TO DRUGS OR X-RAY DYES:

_____
_____
_____

OTHER _____

DATE OF LAST:

Tetanus Inj. _____
Pneumonia vaccine _____
Mammogram _____
Pap smear _____
Colonoscopy _____

CURRENT MEDICATIONS:

_____ _____
_____ _____
_____ _____

OCCUPATION: _____

CURRENT CHRONIC ILLNESSES:
(Such as diabetes or high blood pressure)

_____
_____
_____
_____

HABITS:

Type:	Amount	Frequency
Tobacco	_____	_____
Alcohol	_____	_____
Marijuana	_____	_____
Hard drugs	_____	_____
Coffee/Tea	_____	_____
Other	_____	_____

HOSPITALIZATIONS:

(Surgery or illness)	Date	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST HISTORY *(Check all that apply)*

_____ Diabetes	_____ Venereal disease	_____ Stomach disease/ulcer
_____ High blood pressure	_____ Alcoholism	_____ Gallbladder disease
_____ Thyroid disease/goiter	_____ Heart disease	_____ Kidney disease/stones
_____ Cancer or leukemia	_____ Hepatitis	_____ Bladder problems
_____ Blood disease or anemia	_____ Lung disease	_____ Phlebitis/blood clots
_____ Arthritis	_____ Asthma	_____ Concussion
_____ Skin disease	_____ Pneumonia	_____ Seizures
_____ Hives	_____ Emphysema	_____ Psychiatric problems
_____ Rashes	_____ Tuberculosis	_____ Anxiety/depression
_____ Bronchitis	Other serious illness: _____	

FAMILY HISTORY

__ Diabetes	__ Heart disease	__ Tuberculosis	__ Epilepsy
__ High blood pressure	__ Asthma	__ Cancer	

HISTORY AND PHYSICAL QUESTIONNAIRE

SYSTEMS REVIEW Please check all symptoms that currently apply.

General:
__ Too hot or cold
__ Poor appetite
__ Always tired
__ Trouble sleeping
__ Lack of exercise
__ Always thirsty
__ Crying spells
__ Depressed
__ Anxiety or stress
__ Hopeless outlook
__ Lose temper often
__ Considered suicide
__ Weight loss or gain
__ Sexual difficulty

Head and Neck:
__ Frequent headaches
__ Neck pains
__ Lumps or swelling
__ Difficulty swallowing

Eyes:
__ Blurred vision
__ Seeing double or halos
__ Eye pain
__ Watering or itching
__ Wear eyeglasses
Date of last eye exam:
_____

Ears:
__ Difficulty hearing
__ Hearing aides
__ Buzzing or ringing
__ Earaches or drainage
__ Frequent infections

Mouth:
__ Dental problems
__ Frequent sores
__ Swelling or lumps
__ Hoarse voice or sore throat

Skin:
__ Rashes or sores
__ Change in mole
__ Lumps or swelling
__ Bleed or bruise easily
__ Itching

Neurological:
__ Seizures
__ Numbness
__ Tingling
__ Trembling
__ Fainting spells
__ Change in handwriting

Cardiovascular:
__ Chest pains
__ Dizziness
__ Racing heart
__ Shortness of breath
__ Swollen ankles
__ Leg cramps
__ Irregular pulse
__ Poor circulation

Respiratory:
__ Wheezing
__ Frequent cough
__ Cough up phlegm or blood
__ Sit up to sleep
__ Trouble breathing

Digestive:
__ Frequent indigestion
__ Frequent belching
__ Nausea or vomiting
__ Spit up blood
__ Constipation or diarrhea
__ Black or gray stools
__ Rectal pain or bleeding
__ Change in stools

Urinary:
__ Frequency or urgency
__ Burning or pain
__ Trouble starting
__ Wet pants or bed
__ Dark or bloody urine
__ Nighttime urination

Male Genital:
__ Lumps on testicles
__ Painful testicles
__ Prostate trouble
__ Discharge
__ Burning

Female Genital:
__ Irregular periods
__ Abnormal bleeding
__ Vaginal discharge
__ Itching or odor
__ Severe cramping
__ Hot flashes
__ Menopause
__ Lumps in breast
__ Had a C-section
__ Had abortion
__ # of pregnancies
__ # living children
Date last period:_____
Date last pap: _____

Musculoskeletal:
__ Joint pain
__ Swollen joints
__ Aching muscles
__ Weakness
__ Tingling
__ Handicapped

Nose:
__ Frequent nosebleeds
__ Sinus problems
__ Congestion

Comments:

_____

_____

_____

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…

Southern Oregon Internal Medicine
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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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www.SOInternal.com A Rogue Valley Physicians, PC Clinic

Southern Oregon Internal Medicine
2900 Doctors Park Drive
Medford, OR 97504

Authorization to Release Medical Information

Patient: _____ Date of Birth: _____

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

To:

Fernando Cendejas, M.D
2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2223
Fax: (541) 282-2265

From: (Physician, Clinic, or Person)
(Include phone and/or Fax #)
_____
_____
_____
_____
_____

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

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 _____Pathology Results

_____Lab Results _____Prescription/Samples Information

_____EKG Results _____Mammogram Results (men may also need this…)

_____X-Ray Results _____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.