ORO VALLEY MEDICINE, LLC

1171 E. Rancho Vistoso Blvd.,
Suite 143
Oro Valley, AZ 85755

Phone no: (520) 399-8094 Fax no:(888) 416-1743

PATIENT INFORMATION

Patient's Name: (Last)_____(First)_____(MI)_____SS#_____

Address:_____

City, State, Zip _____

Home:_____Cell:_____Work:_____

E-Mail Address:_____DOB:_____

Sex: Male Female

Race: American Indian/Alaska Native Asian Native Hawaiian/Pacific Islander Black/Africa American White Other Declined

Preferred Language: English Other_____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Declined

Marital Status: Married Divorced Single Significant Other Widowed Other

Employer:_____Employer Phone:_____ Occupation:_____

Status: Part-Time Full-Time Self-Employed Retired Active Military Disabled Unemployed Unknown

PHARMACY

Local :_____Phone Number:_____

Address/Cross Streets:_____

Alternative:_____Phone Number:_____

Address/Cross Streets:_____

Preferred

Mail Order:_____

Address _____

Phone number:_____

Preferred

INSURANCE INFORMATION

Name of Primary insurance:_____Address _____

Subscriber's Name:_____

Patient Relationship: Self Spouse Other

Insurance ID number:_____Policy Group ID:_____

Name of secondary insurance:_____Address _____

Subscriber's Name:_____

Patient Relationship: Self Spouse Other

Insurance ID number:_____Policy Group ID:_____

IN CASE OF EMERGENCY

Emergency contact name(Last)_____(First)_____

Phone number:_____

Emergency contact to patient:_____ Guardian

Address:_____

City, State:_____Zip:_____

Home Phone:_____Cell phone:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Oro Valley Medicine, LLC or insurance company to release any information required to process my claims

Patient/Guardian signature Date

Social History

1. Marital Status: ☐ Single ☐Married/Partner ☐Divorced ☐Separated ☐Widowed
2. Smoking History: ☐ I have **never** smoked
   I currently smoke: ☐ Cigarettes packs/day: _____ ☐ Cigar ☐Pipe ☐eCigarettes ☐Other
   If you currently smoke, are you interested in quitting? ☐Yes ☐ No
   I previously smoked: ☐Cigarettes ☐Cigar ☐Other Age Started: _____ Age Stopped: _____
   Average packs/day:_____Are there smokers in home? ☐Yes ☐
   No Smokeless tobacco: ☐Yes☐ No Number of years: _____
3. Marijuana: ☐Yes ☐ No Route: ☐Inhaled ☐ Edible Medical: ☐Yes ☐ No
4. Street/Illicit Drugs: ☐Yes ☐No If yes, which? _____
5. Alcohol Use: Any problems with alcohol now or in the past? ☐Yes ☐ No
   Current number of drinks per week:_____Type(s) of alcohol: _____
6. Exercise: Do you exercise regularly? ☐Yes ☐ No
   Please Describe: _____
7. Fall Risk: Have you fallen in the past 3 months? ☐ Yes ☐ No
   Do you feel unsteady when standing? ☐ Yes ☐ No
   Do you use a cane, walker or wheelchair? ☐ Yes ☐ No
   Do you have a fear of falling? ☐ Yes ☐ No

Medications Taken Regularly

Include all oral, inhaled, intravenous, and subcutaneous medications as well as all herbal medications, supplements, vitamins and over-the-counter medications. If needed, please provide a separate list.

	Medication Name	Dose	Route (Oral, Inhale)	How Often?
ex	*Lipitor*	*10 mg*	*oral*	*Once daily*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Allergies

Allergic to: ☐ IV Contrast Dye: Type_____

Please list medication or severe food allergies	Describe reaction

Patient Name _____

What would you like to talk about during your visit?

_____

_____

_____

Medical History:

Past Medical History: Have you ever had any of the following?

Allergies	Yes	No	Irregular Heart Rhythm	Yes	No
Anxiety Disorder	☐ Yes	☐ No	Kidney Failure or Disease	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bone Fracture as an Adult	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Bronchiectasis	☐ Yes	☐ No	Obstructive Sleep Apnea	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cancer (**if yes, describe below**)	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Pulmonary Artery Hypertension	☐ Yes	☐ No
Coronary Artery Disease/Heart attack	☐ Yes	☐ No	Pulmonary Fibrosis(**if yes, describe below**)	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Recurrent Infections	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sarcoidosis	☐ Yes	☐ No
DVT or Pulmonary Embolism	☐ Yes	☐ No	Scleroderma	☐ Yes	☐ No
Esophageal Disease	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
GERD/Reflux	☐ Yes	☐ No	Sinusitis	☐ Yes	☐ No
Heart or Valve Defect	☐ Yes	☐ No	Sjogren's	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Skin Disorders (e.g., Psoriasis, Acne)	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Tuberculosis (**if yes, describe below**)	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Mycobacterial Infection	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No	Vocal Cord Dysfunction/Paralysis	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No			

Please list all other medical conditions past and present:

_____

_____

_____

_____

Past Surgical History

Surgery or Procedure	Date of Procedure	Name of Surgeon/Provider

Family History

Indicate if your family members have any of these diseases (GM=Grandmother, GF=Grandfather, Maternal=mother, Paternal=father's side)

Disease	Materna			Paterna			Siblings			Children			
	Mom	GM	GF	Dad	GM	GF							
Asthma													
Autoimmune Disease Type:													
Cancer Type:													
COPD/ Emphysema													
Pulmonary Interstitial Lung Disease													
Coronary artery disease/heart attack													
Diabetes Mellitus													
High cholesterol													
High blood pressure													
Frequent Pneumonia													
Pulmonary embolism (PE)													
Rheumatoid arthritis													
Stroke													
Osteoporosis/ Fragile Bones and/or Hip Fracture													
Other #1													
Other #2													

Other diseases that run in the family: _____

_____

_____

Vaccination/Immunization History

Vaccine/Immunization	Date of Last Immunization Month/Year
Flu (Influenza Shot)	/
Pneumovax (Pneumoccal Pneumonia)	/
Zostavax (Shingles or Herpes Zoster)	/
Tdap (Tetanus-Diptheria Zoster)	/
Other	/

Preventive Care

Please provide the approximate date of your last…	Obtained Where?
Colonoscopy	
Bone Density (DEXA) Scan:	
Dental Exam	
Eye Exam	

For Women Only:

When did menopause begin? _____

Since then, have you noticed any vaginal bleeding? Yes No

Do you take Calcium and Vitamin D supplements? Yes No Dose: _____

Date of last PAP test?_____Results (Normal or abnormal)_____

Have you ever had a mammogram? Yes No

If so, when and where was it last done?_____

For Men Only: Have you ever had…

Rectal exam (digital/finger)? Yes No If so, when?_____

A PSA (Prostate specific Antigen) blood test? Yes No If so, when?_____

Patient Name:_____
Date of Birth:_____

Oro Valley Medicine, LLC - Patient Consent for Financial Communications

Financial Agreement

I acknowledge, that as a courtesy, Oro Valley Medicine may bill my insurance company for services provided to me.

I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.

I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Oro Valley Medicine may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Oro Valley Medicine any insurance or other third-party benefits available for health care services provided to me. I understand Oro Valley Medicine has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Oro Valley Medicine, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Oro Valley Medicine by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Oro Valley Medicine, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Sterling Primary Care or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Sterling Primary Care or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature:_____**Date**:_____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.