Dear Patient,

We would like to thank you for choosing Ironwood Cancer & Research Centers. 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 History Form**
2. **Medication and Allergy List**

The following form is for your information only:

1. **Notice of Privacy Practices (HIPAA)**

Additionally, please also bring your ***insurance card, prescription drug coverage information, a picture ID, and a list of your current medications and dosages.*** Please arrive 30 minutes before your scheduled appointment time for your first visit. Maps to all of our locations are located on our website: www.ironwoodcrc.com. If you have any questions, please call any of our office locations for assistance.

Please note: There may be delay of scheduling your appointment if your insurance company requires an electronic referral from your Primary Care for your visit - **Please reach out to your Primary Care Provider. If an authorization is required for any testing from your insurance company, please be advised there may also be a delay in scheduling your appointment.

Thank You

Name: ______________________ Date: ____________ DOB: ______________

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	☐ 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)*: Pacemaker

☐ **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

Name: ______________________ Date: ______________ DOB: ______________

Ironwood Physicians, PC

PATIENT HISTORY FORM

REPRODUCTIVE HISTORY

For female patients only

Age at first period? ________ Number of pregnancies? ________ Number of births? ________ Age at 1st birth? ________

Have you gone through menopause? ☐ Yes ☐ No If yes, at what age? ________ Last Menstrual Cycle ________

Have you ever taken oral contraceptive pills? ☐ Yes ☐ No When: ________________

Have you ever taken any medications for treatment of infertility? ☐ Yes ☐ No When? ________________

Have you had a tubal ligation: ☐ Yes ☐ No When? ________________

Is your flow ☐ Regular or ☐ Irregular How often? ________________ How long? ________________

How many pads/tampons do you use in a day? ________ Any pain, bleeding or blood clots? ☐ Yes ☐ No

Have you ever had a breast biopsy before? ☐ Yes ☐ No How many have you had? ________________

If Yes, were any abnormal? ☐ Yes ☐ No Explain: ________________

Have you ever taken hormone replacement therapy? ☐ Yes ☐ No When: ________________

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:

____

____

CANCER FAMILY HISTORY

Please indicate any family cancer.

Relative:	Type of Cancer:	Age at Diagnosis:	Lineage (Maternal or Paternal side)

Please answer these additional questions if applicable

Is there a known hereditary cancer predisposition syndrome in your family? ________________

Are you aware of prior genetic testing in any of your family members with cancer? If yes, what are the results? ________________

Do you have Jewish ancestry on either maternal or paternal side? ________________

To be completed by patients with bleeding or clotting problems

Is there a known hereditary bleeding or clotting disorder that runs in your family? ________________

Is there a family history of blood clots or bleeding disorder? ________________

Name: ____________________ Date: ____________ DOB: ____________

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 check: 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

Name: ______________________ Date: ______________ DOB: ______________

Ironwood Physicians, PC

REVIEW OF SYSTEMS

System Review

Please check if you are experiencing any of the following symptoms

GENERAL:

☐ Yes / ☐ No Fever
☐ Yes / ☐ No Fatigue
☐ Yes / ☐ No Night sweats
☐ Yes / ☐ No Weight Gain
☐ Yes / ☐ No Weight loss

SKIN:

☐ Yes / ☐ No Bruising
☐ Yes / ☐ No Itching
☐ Yes / ☐ No Rash

HEAD/NECK:

☐ Yes / ☐ No Frequent Sore Throats
☐ Yes / ☐ No Hearing Loss
☐ Yes / ☐ No Hoarseness
☐ Yes / ☐ No Change in voice
☐ Yes / ☐ No Vision Changes

MUSCULOSKELETAL/ MOVEMENT:

☐ Yes / ☐ No Back Pain
☐ Yes / ☐ No Wheelchair
☐ Yes / ☐ No Cane or Walker

BREAST:

☐ Yes / ☐ No Armpit Lumps/Masses
☐ Yes / ☐ No Breast Lumps/Masses
☐ Yes / ☐ No Nipple Discharge
☐ Yes / ☐ No Pain
☐ Yes / ☐ No Skin Changes

HEART/LUNG:

☐ Yes / ☐ No Chest Pain
☐ Yes / ☐ No Pain in Legs
☐ Yes / ☐ No Palpitations
☐ Yes / ☐ No Swollen Ankles
☐ Yes / ☐ No Cough
☐ Yes / ☐ No Coughing Blood
☐ Yes / ☐ No Shortness of Breath
☐ Yes / ☐ No Use Oxygen at home

ENDOCRINE/LYMPHATIC:

☐ Yes / ☐ No Cold Intolerance
☐ Yes / ☐ No Excessive Sweating
☐ Yes / ☐ No Excessive Thirst
☐ Yes / ☐ No Heat Intolerance
☐ Yes / ☐ No Hot Flashes
☐ Yes / ☐ No Bone Pain
☐ Yes / ☐ No Swollen Lymph Nodes

NEUROLOGICAL:

☐ Yes / ☐ No Balance Problems
☐ Yes / ☐ No Dizziness
☐ Yes / ☐ No Headaches
☐ Yes / ☐ No Numbness/Tingling
☐ Yes / ☐ No Seizures

KIDNEY/BLADDER:

☐ Yes / ☐ No Blood in Urine
☐ Yes / ☐ No Frequency of Urination
☐ Yes / ☐ No Getting up at Night
☐ Yes / ☐ No Pain when Urinating
☐ Yes / ☐ No Urgency of Urination

GASTROINTESTINAL:

☐ Yes / ☐ No Black/Tarry/Clay Stools
☐ Yes / ☐ No Constipation
☐ Yes / ☐ No Diarrhea
☐ Yes / ☐ No Difficulty Swallowing
☐ Yes / ☐ No Nausea
☐ Yes / ☐ No Poor Appetite
☐ Yes / ☐ No Rectal Bleeding
☐ Yes / ☐ No Vomiting

PSYCHOLOGIC:

☐ Yes / ☐ No Anxiety
☐ Yes / ☐ No Depression
☐ Yes / ☐ No Nervousness

GYNECOLOGIC:

☐ Yes / ☐ No Irregular Periods
☐ Yes / ☐ No Painful Periods
☐ Yes / ☐ No Painful Intercourse
☐ Yes / ☐ No Vaginal Bleeding
☐ Yes / ☐ No Vaginal Discharge
☐ Yes / ☐ No Vaginal Dryness

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.

NORIDIAN®
Administrative Services LLC

Providing high quality administrative services to Medicare since 1966

Medicare Part B

Only Applies to Patients 65 years of age or older

Coverage Screening Checklist

1. **Do you have any medical coverage other than Medicare?**

- **Work insurance**
- **Disability**
- **Group Health Plan**
- **No-fault**
- **Worker's Comp**
- **Spousal coverage**
- **Liability**
- **VA**

☐ **Yes**	Enter Company or Plan name: ____________________ Company or Plan phone number: __(_____)____________________
☐ **No**	Go to Question 2

2. **Are you currently enrolled/covered by a Health Maintenance Organization (HMO), Managed Care Organization, Medicare Advantage, or Part C plan?**

☐ **Yes**	Enter Company or Plan name: ____________________ Company or Plan phone number: __(_____)____________________
☐ **No**	Go to Question 3

3. **Do you currently reside in a nursing facility?**

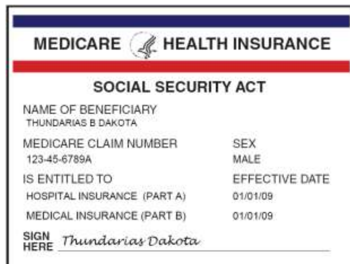
☐ **Yes**	Enter Nursing Facility name: ____________________ Nursing Facility phone number: __(_____)____________________
	Are you receiving skilled care? ☐ Yes ☐ No
☐ **No**	Go to Question 4

4. Do you currently receive any home health care?

☐ **Yes**	Enter Home Health provider name: ________________________________ Home Health phone number: __(_____)__________________________
☐ **No**	Go to Question 5

5. Are you currently under a hospice plan of care?

☐ **Yes**	Enter Hospice name: ________________________________ Hospice phone number: __(_____)__________________________
☐ **No**	Form is now complete



Please present your red, white and blue Medicare card with this form.

Ironwood Cancer & Research Centers

Outsmarting Cancer One Patient at a Time™

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. I understand that I have a right to a Notice of Privacy Practices from Ironwood Physicians, PC. Please read carefully.

Uses and Disclosures

- *Treatment.* Your health information may be used by staff members or disclosed to other healthcare professionals for the purposes of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
- *Payment.* Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
- *Healthcare Operations.* Your health information may be disclosed as necessary to support the day-to-day activities and management of **Ironwood Physicians PC.** For example, information on the services you received may be used to support the budgeting and financial reporting, and activities to evaluate and promote quality.
- *Law Enforcement.* Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
- *Public Health Reporting.* Your health information may be disclosed to public health agencies as required by state law. For example, we are required to report certain communicable diseases to the state's public health department.
- *Research.* We conduct clinical research here. Our clinical research staff may look at your health records as part of your current care to determine if you may be eligible for any research studies being done at our facility. All patient research conducted at Ironwood Cancer & Research Centers goes through a special process required by law that reviews protections for patients involved in research, including privacy. *We will not use your health information or disclose it outside of Ironwood Cancer & Research Centers for research reasons without getting your prior written approval or determining that your privacy is protected.*
- ***Other uses and disclosures require your authorization***. Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Ironwood Physicians, PC offices

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice of your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

Complaints/Contact Person

If you would like to submit a question, comment, or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer/Administrator
Ironwood Cancer & Research Centers
695 S. Dobson Rd.
Chandler, AZ. 85224

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.