



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: _____ ☐ OK TO LEAVE A DETAILED VOICEMAIL? Y/N
 CELL: _____ ☐ ARE YOU CURRENTLY WORKING? Y/N
 OTHER: _____ ☐ DISABLED? Y/N RETIRED? Y/N
 EMAIL: _____ ☐ 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 #: _____

For office use only.



**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):*

☐ **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: _____ ACCT #: _____

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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? _____



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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 PRESCRIPTIONS 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



Ironwood Physicians, PC

REVIEW OF SYSTEMS

SYSTEM REVIEW

Please check if you are experiencing any of the following symptoms

GENERAL:

- ☐ Yes / ☐ No Chills
- ☐ Yes / ☐ No Fever
- ☐ Yes / ☐ No Fatigue
- ☐ Yes / ☐ No Generalized Weakness
- ☐ Yes / ☐ No Night sweats
- ☐ Yes / ☐ No Trouble Sleeping
- ☐ Yes / ☐ No Weight Gain
- ☐ Yes / ☐ No Weight loss

SKIN:

- ☐ Yes / ☐ No Bruising
- ☐ Yes / ☐ No Chronic Skin Condition
- ☐ Yes / ☐ No Itching
- ☐ Yes / ☐ No Lesions/Boils
- ☐ Yes / ☐ No Nail Changes
- ☐ Yes / ☐ No Rash
- ☐ Yes / ☐ No Sores

HEAD/NECK:

- ☐ Yes / ☐ No Discharge from Ears
- ☐ Yes / ☐ No Dry Mouth
- ☐ Yes / ☐ No Frequent Sore Throats
- ☐ Yes / ☐ No Hearing Loss
- ☐ Yes / ☐ No Hoarseness
- ☐ Yes / ☐ No Nose Bleeds
- ☐ Yes / ☐ No Ringing/Pain in Ears
- ☐ Yes / ☐ No Sores/Ulcers in Mouth
- ☐ Yes / ☐ No Vision Changes

MUSCULOSKELETAL/ MOVEMENT:

- ☐ Yes / ☐ No Back Pain
- ☐ Yes / ☐ No Decreased Range of Motion
- ☐ Yes / ☐ No History of Fractures
- ☐ Yes / ☐ No Wheelchair, 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 Sleep w/Head Elevated
- ☐ Yes / ☐ No Sputum/Mucus
- ☐ Yes / ☐ No Use C-PAP at home
- ☐ Yes / ☐ No Use Oxygen at home
- ☐ Yes / ☐ No Wheezing

ENDOCRINE/LYMPHATIC:

- ☐ Yes / ☐ No Cold Intolerance
- ☐ Yes / ☐ No Excessive Hunger
- ☐ Yes / ☐ No Excessive Sweating
- ☐ Yes / ☐ No Excessive Thirst
- ☐ Yes / ☐ No Heat Intolerance
- ☐ Yes / ☐ No Hot Flashes
- ☐ Yes / ☐ No Joint/Bone Pain
- ☐ Yes / ☐ No Painful Lymph Nodes
- ☐ Yes / ☐ No Swollen Lymph Nodes
- ☐ Yes / ☐ No Sexual Dysfunction

NEUROLOGICAL:

- ☐ Yes / ☐ No Balance Problems
- ☐ Yes / ☐ No Claustrophobia
- ☐ Yes / ☐ No Dizziness
- ☐ Yes / ☐ No Fainting
- ☐ Yes / ☐ No Headaches
- ☐ Yes / ☐ No Numbness/Tingling
- ☐ Yes / ☐ No Seizures
- ☐ Yes / ☐ No Tremors

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

KIDNEY/BLADDER:

- ☐ Yes / ☐ No Blood in Urine
- ☐ Yes / ☐ No Cloudy Urine
- ☐ Yes / ☐ No Frequency of Urination
- ☐ Yes / ☐ No Getting up at Night
- ☐ Yes / ☐ No Hesitancy of Urination
- ☐ Yes / ☐ No Incontinence
- ☐ Yes / ☐ No Leakage/Retention
- ☐ Yes / ☐ No Pain when Urinating
- ☐ Yes / ☐ No Passed Stones
- ☐ Yes / ☐ No Urgency of Urination

GASTROINTESTINAL:

- ☐ Yes / ☐ No Black/Tarry/Clay Stools
- ☐ Yes / ☐ No Bloating
- ☐ Yes / ☐ No Constipation
- ☐ Yes / ☐ No Diarrhea
- ☐ Yes / ☐ No Difficulty Swallowing
- ☐ Yes / ☐ No Heartburn
- ☐ Yes / ☐ No Hemorrhoids
- ☐ Yes / ☐ No Incontinence of Stool
- ☐ Yes / ☐ No Nausea
- ☐ Yes / ☐ No Painful Swallowing
- ☐ Yes / ☐ No Poor Appetite
- ☐ Yes / ☐ No Rectal Bleeding
- ☐ Yes / ☐ No Vomiting
- ☐ Yes / ☐ No Vomiting Blood
- ☐ Yes / ☐ No Yellowing of Skin/Eyes

PSYCHOLOGIC:

- ☐ Yes / ☐ No Anxiety
- ☐ Yes / ☐ No Depression
- ☐ Yes / ☐ No Memory Changes
- ☐ Yes / ☐ No Nervousness



**Ironwood
Physicians, PC**

Consent to Release Protected Health Information

Name: _____ Date: _____

I authorize Ironwood Physicians, PC to use/disclose my personal health information to the individuals listed on this form.

1. Contact Name:

Phone:

Phone
(other):

Address:

Relationship: ☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Other (Describe) _____

2. Contact Name

Phone:

Phone
(other):

Address:

Relationship: ☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Other (Describe) _____

3. Contact Name:

Phone:

Phone
(other):

Address:

Relationship: ☐ Spouse ☐ Family (Describe) _____ ☐ Friend ☐ Other (Describe) _____

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

Patient Signature: _____ Date: _____

Personal Representative Signature: _____ Date: _____

Relationship to Patient: _____



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: _____



**Ironwood
Urology**

15920 S 48th ST, Suite 100

Phoenix, AZ 85048

Phone: (480)961-2323 | Fax: (480)961-2325

690 E WARNER RD, Bldg 5

Gilbert, AZ 85296

Phone: (480) 664-0261 | Fax: (480) 664-0281

Authorization to release Protected Health Information (PHI) to Ironwood Urology

(For the purpose of continuing patient care)

Patient Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Daytime telephone number _____

I hereby authorize the hospital or medical facility in receipt of this form to disclose the following Protected Health Information pertaining to the above referenced patient to:

Ironwood Urology

- ☐ Please release all pertinent records from the dates of _____ to _____

OR

- ☐ Please release the following information:

I understand that this authorization covers records relating to communicable disease, Acquired Immunodeficiency (“AIDS”), Human Immunodeficiency Virus (“HIV”), behavioral, and/or drug abuse treatment, genetic testing, if any such records exist.

I understand that at any time I have the right to revoke on the authorization for release medical records, except if the recipient has already taken action on this authorization. I understand that in order to revoke this authorization I must do so in writing, and send my revocation to the recipient.

I understand that, once this information has been disclosed to a third party, that the information may not be protected by Federal Privacy Regulations and may be re-disclosed by the third party or entity that has the received this information. I also understand that Ironwood Urology will not re-disclose my Protected Health Information without my written consent.

I understand that this authorization does, and will expire one year from the date of signing unless an earlier date is specified in writing.

Signature _____ Date _____

Print Name _____ Relationship to Patient _____



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