IRONWOOD
Family Practice

Dear Patient,

The visit you have scheduled today is for an **Annual Physical Exam**. It will be billed as such to your insurance company. Your insurance company may call this a **Preventative Care Exam** or a **Routine Wellness Exam**.

Your insurance company may not require a co-pay or deductible for your Annual Physical, however ***it is the office policy of Ironwood Family Practice that a co-payment is required at the time of your visit***. This will be reimbursed to you or applied towards your account if there is a balance after insurance makes a payment. If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate as "patient responsibility".

Due to coding laws, we **MUST** bill your Annual Physical as Preventative Care. Your insurance plan **MAY or MAY NOT** cover routine (preventive) care. Feel free to call the insurance company and ask about your coverage. There are many plans and your benefits can change often.

We are legally obligated to assign procedure code(s) based on the service provided to you, whether it is an Annual Physical Exam, a visit to take care of problems, or both. Based on the kind of coverage you have, **SOME (OR ALL)** of this cost may have to be billed to you.

Please **DO NOT ASK US TO RE-BILL** your insurance by changing the procedure or diagnosis code(s). We are unable to make a change once the insurance has been billed for an Annual Physical. We apply procedure and diagnosis codes based on the examination performed and cannot change these to reflect those covered by your insurance.

Please indicate below the purpose of your visit today as you understand it:

Annual Physical _____

Annual Physical and Problem Focused Exam _____

Problem Focused Exam _____

NOTE: Certain tests we order as part of your Annual Physical Exam **MAY or MAY NOT** be covered by your insurance. This includes, but is not limited to: blood work, audiometry (hearing test), and x-rays.

We appreciate your understanding and cooperation.

I acknowledge that I have read and understand the information stated above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility".

_____ _____

Patient/ Legal Guardian Signature Date

_____ _____

Patient Name (Print) Date of Birth

IRONWOOD Family Practice

Interval Health History Questionnaire

Date: _____

Patient Name: _____ Date of Birth: _____

** An accurate medical, social and family history is very important for us to know in order to better assess your current medical health and influences on future health and well-being.*

Please circle any of the following you are currently experiencing:

GENERAL	EYES	ENT	CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	GENITOURINARY
Fatigue	Blurred Vision	Hearing Problems	Chest Pain/Pressure	Cough—Acute	Abdominal pain	Painful Urination
Fever	Eye Drainage	Ear Ringing	Dizziness	Cough—Chronic	Diarrhea	Blood in Urine
Night Sweats	Eye Pain	Nosebleeds	Palpitations	Shortness of breath	Blood in stool	Frequent Urination
Weight Gain	Light Sensitivity	Hoarseness	Feet Swelling	Blood-Tinged Sputum	Nausea	Incontinence
Weight Loss	Double Vision	Sore Throat	Varicose Veins	Wheezing	Vomiting	Flank Pain

MUSCULOSKELETAL	SKIN/BREASTS	NEUROLOGICAL	HEMATOLOGIC/LYMPHATIC	ENDOCRINE	MALE	PSYCHOLOGIC
Joint Pain	Lesions/Moles	Fainting	Easy Bruising	Hair Loss	ED	Depression
Back Pain	Itching	Headaches	Excessive Bleeding	Heat/Cold Intol	Impotence	Anxiety
Joint Stiffness	Rash	Confusion/Memory Loss	Lymph Node Swelling	Excess Thirst		Severe Stress
Extremity Pain	Breast Mass	Numbness/Tingling	Anemia	Excess Sweat		Sleep Disturbance
Muscle Pain	Breast Tenderness	Seizure				

- Have you had any ***RECENT*** surgeries or major procedures that we may not have in your chart?

  _____

- Have you had any ***RECENT*** major illnesses or hospitalizations we have not discussed in the past?

  _____

- Do you have any ***NEW*** intolerances or allergic reactions to medications or foods we may not already have noted in your chart? If so, what were the reactions – rash, difficulty breathing, itching, confusion, nausea, etc.?

  _____

- Do you have any ***NEW*** diagnoses or medical problems we may not already have noted in your chart?

  _____

- FAMILY MEDICAL HISTORY: Are there any ***NEW*** medical illnesses affecting family members that may not yet be noted in your chart? Ex: Heart disease, stroke, diabetes, hypertension, migraines, depression, cancer.

  _____

- Please list your preferred pharmacy: _____

SOCIAL HISTORY:

- Who lives in your current household?

  _____

- Do you feel safe at home? _____
  - If not, what makes you fearful? _____
- Has anyone ever hit, kicked, pushed or verbally intimidated you? _____
- Do you have any current major home, work, social or financial stressors affecting your life and/or health?

  _____

- Do you have difficulty sleeping? _____ How many hours of sleep do you get each day? _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems? (*please circle*)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite--being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns _____ + _____ + _____

TOTAL: _____

10. If you checked off *any problems,* how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult