Heather A. Kahn MD, PC
Cheryl Giles, FNP-C

ROGUE MEDICINE

702 SW Ramsey Ave, Ste 120
Grants Pass, Oregon 97527
541-244-2197

WELCOME!

Thank you for selecting **Rogue Medicine** for your health care.

Our goal is to provide you with quality patient care. Please complete the enclosed patient information and return to our office. We appreciate receiving the information in advance of your appointment so we can begin your medical record. Once the information is received we can schedule your new patient appointment. We allow 45 minutes for your first visit.

Our office is contracted with many insurance carriers. To avoid any confusion, please contact your insurance carrier to insure Rogue Medicine is contracted with them. We are happy to help you.

Rogue Medicine and staff look forward to meeting your medical health care needs.

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PATIENT REGISTRATION

PATIENT INFORMATION

Last name_____ First_____ Middle_____ Date of birth_____

Street address_____

Mailing address (☐ check if same as street address)_____

City_____ State_____ Zip_____

Phone_____ May we leave information at this number to confirm your appointment? ☐ Yes ☐ No

Sex ☐ F ☐ M Marital status ☐ Single ☐ Married ☐ Other SS#_____

Employment status ☐ Employed ☐ Not employed ☐ Full-time student ☐ Part-time student ☐ Retired

Employer_____ Phone_____

Employer address_____

Whom may we thank for referring you?_____

With whom may we share your healthcare information?

Name_____ Relation_____

Emergency contact_____ Phone_____

Current pharmacy_____ Phone_____

Previous healthcare provider_____ Phone_____

INSURANCE INFORMATION

Primary insurance_____ Group ID_____ Member ID_____

Secondary insurance_____ Group ID_____ Member ID_____

Note: AllCare Health is the only Oregon Health Plan (OHP) our office accepts. AllCare Health ID_____

☐ Check if patient is responsible. If responsible party is someone other than patient, complete info below.

Last name_____ First_____ Middle_____ Phone_____

This person is: ☐ my parent ☐ my spouse ☐ someone else Relationship_____

Address (☐ check if same as patient address)_____

City_____ State_____ Zip_____

SS#_____ Date of birth_____ Employer_____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Rogue Medicine to provide my insurance companies with all information necessary to process insurance claims and assign payments to Rogue Medicine all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. If it becomes necessary to effect collections for any amount owed, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Patient or guarantor signature_____ Date_____

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ADULT HEALTH HISTORY

It is important that you complete this form in full, including all dates.

PATIENT INFORMATION

Name (please print)_____ Date of birth_____

Primary Care provider_____ Today's date_____

MEDICAL HISTORY

Medical condition	Current?	Date diagnosed	Provider seen	*(Office use)*
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			

ALLERGIES

☐ No allergies

Allergic to:	**Reaction**	**Allergic to:**	**Reaction**

MEDICATIONS

Please include anything you are taking, including over-the-counter medications, herbal supplements, and vitamins.

Name	Current?	Prescribed by	What condition are you taking this medication for?	Dose	How do you take this medication
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				

SURGERIES

Be sure to include the year you had the surgery.

Surgery/Procedure	Date	Physician/Surgeon

HEALTH MAINTENANCE

What is the date of your last:

Colonoscopy	
Tetanus vaccine	
Pneumonia vaccine	

WOMEN'S HEALTH HISTORY

If you are a woman, please fill in the information below.

Age menses started	
Age first child was born	
Age/year menopause	
Date of last PAP	
Date of last mammogram	
Total # of pregnancies	
# of full-term pregnancies	
# of pre-term pregnancies	
# of miscarriages	
# of abortions	
# of ectopic or tubal pregnancies	
# of live births - vaginal delivery	
# of live births - cesarean section	
# of children living now	

EDUCATION / MILITARY EXPERIENCE

High School graduate or GED equivalent? ☐ Y ☐ N

College ☐ Some ☐ Degree: _____

Military experience _____

EMPLOYMENT

Employer _____

Occupation _____

☐ Part-time ☐ Full-time ☐ Retired ☐ Disabled

FAMILY HISTORY

Have any of your relatives had any of the following?

Diagnosis	Relationship	Living?
ADD / ADHD		☐ Y ☐ N
Alcoholism		☐ Y ☐ N
Allergies		☐ Y ☐ N
Alzheimer's Disease		☐ Y ☐ N
Arthritis		☐ Y ☐ N
Asthma		☐ Y ☐ N
Bipolar Disorder		☐ Y ☐ N
Birth Defect type: _____		☐ Y ☐ N
Blood Disease		☐ Y ☐ N
Cancer type: _____		☐ Y ☐ N
CVA (Stroke)		☐ Y ☐ N
Depression		☐ Y ☐ N
Developmental Delay		☐ Y ☐ N
Diabetes		☐ Y ☐ N
Eczema		☐ Y ☐ N
Heart Disease		☐ Y ☐ N
High Cholesterol		☐ Y ☐ N
High Blood Pressure		☐ Y ☐ N
Learning Disability		☐ Y ☐ N
Lung Disease		☐ Y ☐ N
Mental Illness		☐ Y ☐ N
Migraines		☐ Y ☐ N
Obesity		☐ Y ☐ N
Osteoporosis		☐ Y ☐ N
Renal Disease		☐ Y ☐ N
Seizure Disorder		☐ Y ☐ N
Thyroid Disease		☐ Y ☐ N
Other: _____		☐ Y ☐ N
Other: _____		☐ Y ☐ N
Other: _____		☐ Y ☐ N

TOBACCO

Do you use tobacco? ☐ Y ☐ N

Type_____

How much/day?_____ Number of years_____

Have you tried to quit before? ☐ Y ☐ N

If yes, method?_____

☐ I quit Year_____

Passive (second-hand) smoke exposure? ☐ Y ☐ N

ALCOHOL

Do you drink alcohol? ☐ Y ☐ N

Type_____

How much?_____

How often? ☐ Daily ☐ Weekly ☐ Socially ☐ Binge

☐ I quit Year_____

CAFFEINE

Do you consume caffeine? ☐ Y ☐ N

Type_____

How much?_____

How often?_____

RECREATIONAL DRUGS

Do you take recreational drugs? ☐ Y ☐ N

Type_____

How much?_____

How often?_____

☐ I quit Year_____

EXERCISE/ACTIVITY

What is your normal activity level?

☐ Sedentary ☐ Moderate ☐ Athletic

How many hours per week do you exercise?_____

HOME ENVIRONMENT / SAFETY

Home heating type_____

DENTAL

Dentist_____

Date of last exam_____

ADVANCE DIRECTIVE

Below, check all documents you have in place:

☐ None

☐ Living Will

☐ Power of Attorney

☐ Healthcare Proxy

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SYMPTOM QUESTIONNAIRE

Name_____ Date of birth_____

If you currently have any of these symptoms, please check box:

CONSTITUTIONAL
- ☐ Weight gain
- ☐ Weight loss

EYES
- ☐ Glasses
- ☐ Vision loss
- ☐ Trauma

HEAD
- ☐ Dizziness
- ☐ Headache
- ☐ Ringing in ears
- ☐ Trauma
- ☐ Seizures
- ☐ Ear infections
- ☐ Hearing loss
- ☐ Runny nose
- ☐ Can't breathe out
- ☐ Nose bleeds
- ☐ Nasal polyps
- ☐ Sores in mouth
- ☐ Dentures
- ☐ Jaw clicking
- ☐ Hoarseness
- ☐ Voice changes
- ☐ Trouble swallowing
- ☐ Stiffness

SKIN
- ☐ Rash or acne
- ☐ Itching
- ☐ Bruising
- ☐ Scaling
- ☐ Hair loss
- ☐ Unusual hair growth
- ☐ Dry hair
- ☐ Oily hair
- ☐ Brittle nails
- ☐ Ridged nails

NEUROLOGIC
- ☐ Numbness and tingling
- ☐ Hypersensitive skin
- ☐ Coordination problem

CARDIOVASCULAR
- ☐ Irregular heartbeat
- ☐ Leg pain with extension
- ☐ Fluttering
- ☐ Pain with exertion
- ☐ Swelling in legs
- ☐ Fast heartbeat
- ☐ Fainting
- ☐ Varicose veins

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Cough
- ☐ Mucous

GUT
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain with eating
- ☐ Appetite changes
- ☐ Belly pain
- ☐ Hemorrhoids
- ☐ Weight changes
- ☐ Reflux/ulcer
- ☐ Bowel problems

GENITOURINARY
- ☐ Wake up at night
- ☐ Incontinence
- ☐ Kidney/bladder infection
- ☐ Sexually active
- ☐ Sexual dissatisfaction

PSYCHIATRIC
- ☐ Depression
- ☐ Sleep problems
- ☐ Anxiety
- ☐ Other

ENDOCRINE
- ☐ Frequent voiding
- ☐ More thirsty
- ☐ Heat/cold intolerance
- ☐ Fatigue

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Muscle weakness

BREASTS
- ☐ Masses
- ☐ Discharge
- ☐ Pain

BLOOD-LYMPH
- ☐ Anemia
- ☐ Swollen lymph nodes

ALLERGIC-IMMUNOLOGIC
- ☐ Sinus allergy symptoms
- ☐ Allergic dermatitis
- ☐ Frequent illness

IMMUNIZATIONS
- ☐ Tetanus
- ☐ Pneumonia
- ☐ Shingles

INFECTIOUS DISEASE
- ☐ Chicken pox
- ☐ Scarlet/rheumatic fever
- ☐ Hepatitis
- ☐ Sexually transmitted diseases
- ☐ Tuberculosis

HABITS
- ☐ Tobacco
- ☐ Alcohol
- ☐ Coffee
- ☐ Street drugs
- ☐ Exercise

Additional comments_____

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PATIENT ACCOUNT POLICY

Rogue Medicine provides quality health care and administers all accounts under the following guidelines.

Insurance Billing	As a courtesy to our patients with insurance, upon receipt of the appropriate insurance information, we will submit your insurance claim for you. Patients are responsible for all deductibles, co-payments and other patient balances as indicated by your insurance carrier.
Secondary Insurance	We will bill your secondary or supplemental insurance for you.
Co-Pays	Any co-payments required by an insurance company must be paid at time of service.
Scheduling	Patients are asked to arrive 15 minutes before their appointment to allow for registration and rooming. Late arrival may result in asking you to reschedule to not disrupt the appointments of other patients. Patients failing to keep their scheduled appointment without 24 hour notice will be charged $25.00 for the missed appointment. This is patient responsibility and is not covered by your health plan.
Cash Pay Accounts	Patients without insurance must pay cash at the time of our service. A financial plan may be set up in advance with our billing department, but in no instance do we carry an account balance beyond 3 months from the date of service.
Payment Methods	**Payment methods include Cash, Check, MasterCard, and Visa.** A $35 fee will be assessed by our office for any returned checks in addition to the service charge assessed by our bank.
Medicare Patients	Rogue Medicine participates and accepts assignment with Medicare.
Forms	There are fees for forms that the providers are asked to complete. In some instances, the provider may ask you to make an appointment to properly complete the form. Form completion fees are not covered by insurance and are to be paid at time of form request. Please check with our staff for form fees.
Prescriptions	Refills require a 72 hour advance notice. Please contact your pharmacy and they will electronically notify us of the refill request. Medications are not filled after hours or weekends.
Monthly Billing Statements	Mid Rogue eHealth Service handles our billing and statements. You will receive statements directly from them. After your insurance has processed your claim any unpaid patient balances are due upon receipt of our billing statement. Monthly payments will be required under terms established with our billing department, but in no event will exceed 3 months. If you have special financial needs, please contact our billing department to discuss the possibility of an extension of credit.

The billing service contact number is 541-471-3799, option 2.