Southern Oregon Wellness Clinic
547 E Pine St., Suite 101
Central Point, OR 97502
541-973-2551
541-973-2835
sowellnessclinic.com

CONDITIONS OF SERVICES RENDERED

FINANCIAL AGREEMENT: I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account with Southern Oregon Wellness Clinic in accordance with the regular rates and terms. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize, whether I sign as agent or as patient, direct payment to Southern Oregon Wellness Clinic of any insurance benefits otherwise payable to or on behalf of the patient for the visit or for these outpatient services at a rate not to exceed Southern Oregon Wellness Clinic's actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

HEALTH PLAN OBLIGATIONS: Southern Oregon Wellness Clinic maintains a list of health plans with which it contracts. Southern Oregon Wellness Clinic has no contract, expressed or implied, with any plan that does not appear on that list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by Southern Oregon Wellness Clinic if he/she belongs to a plan, which does not appear on the above-mentioned list.

RELEASE OF INFORMATION: I authorize Southern Oregon Clinic to release any information necessary to provide medical treatment to me, allow Southern Oregon Wellness Clinic to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Southern Oregon Wellness Clinic is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective as long as necessary to obtain payment.

The Terms and conditions of this agreement are not binding until the patient receives care and treatment from Southern Oregon Wellness Clinic. The undersigned certifies that he/she had read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE: _____ PRINT NAME: _____

SIGNATURE: _____
(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by other than patient, indicate relationship: _____

****** ATTENTION PATIENTS ******
Scheduled appointments that are not cancelled 48 hours in advance may incur a fee.

PATIENT ACKNOWLEDGEMENT FORM

Receipt of Joint Notice of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of Southern Oregon Wellness Clinic's *Notice of Privacy Practices*. Southern Oregon Wellness Clinic is permitted to use or disclose my health information to carry out treatment, payment or health care operations. Health information means any and all information relating to health care services provided to me, including information related to services provided to me prior to the date I sign the acknowledgement form.

I understand the Southern Oregon Wellness Clinic's Notice of Privacy Practices explains the types of uses or disclosures that Southern Oregon Wellness Clinic may make and my rights with respect to my health information. I understand that if I have any questions or concerns about this Notice, I may contact the Office Manager at the telephone number listed below. I further understand Southern Oregon Wellness Clinic may change the terms of the Notice of Privacy Practices from time to time, and that I may contact the Office Manager to obtain a revised version of the notice at any time.

Patient's Printed Name: _____Patient's DOB: _____

Signature of Patient: _____Date: _____

Signature other than patient: _____Date: _____

If signed by other than patient, indicate relationship: _____

You may contact our office regarding your privacy by calling 541-973-2551

Please Print:

Patient name _____ Date of birth_____

Mailing address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____SSN# _____-_____-____

Email: _____Male _____ Female _____ Single _____ Married _____ Divorced ____ Widowed___

Emergency Contact/ who may we release personal information to?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Medical Insurance Information

Primary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Secondary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Responsible Party:

Name _____ Relationship _____ Phone _____

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

DOB: _____ *Confidential Phone (where confidential messages can be left): _____
Referring Physician/Person: _____ Pharmacy: _____
Reason for today's visit: _____
Emergency Contact: _____ Phone: _____Relationship: _____

PAST MEDICAL HISTORY: Have you had any of the following conditions?

☐ Diabetes	☐ High Blood Pressure	☐ Lung Disease
☐ Liver Disease	☐ Tuberculosis	☐ Depression/Anxiety
☐ Acid Reflux or Hiatal Hernia	☐ Abnormal Skin Test	☐ Brain or Nerve Disease
☐ Thyroid Disorder	☐ Seizures	☐ Ulcers
☐ Heart Disease/Problems	☐ Cholesterol Problem	☐ Kidney Disease/Stones
☐ Arthritis	☐ Blood Clots or Phlebitis	☐ Osteoporosis
☐ Migraine	☐ Environnemental Allergies	☐ Cancer, Type: _____
☐ Sexually Transmitted Disease	☐ Asthma	☐ Other: _____

OPERATION/HOSPITALIZATIONS (Include Tonsillectomy and Appendectomy)

Date	Type	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SEVERE ACCIDENTS INJURIES

_____ Date: _____
_____ Date: _____

ALLERGIES AND ADVERSE MEDICATION REACTIONS

_____	_____	_____

MEDICATIONS CURRENTLY TAKING Regular or occasionally. Include vitamins, birth control pills, sleeping pills, pain pills, laxatives, and aspirin. **(LIST NAME, MG, and HOW OFTEN YOU TAKE MEDICATION (1 time daily, 2 times daily, ECT.)**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VACCINE HISTORY

Flu Shot ☐ Yes ☐ No When: _____ Hepatitis B Vaccine: ☐ Yes ☐ No When: _____
Tetanus Booster ☐ Yes ☐ No When: _____ Covid-19 Vaccine: Yes ☐ No ☐ When: _____
Pneumonia Vaccine ☐ Yes ☐ No When: _____ Prev visit when: _____ Colonoscopy:_____

SOCIAL HISTORY Pap:_____ Mammogram:_____ Dexa:_____

Alcohol use: # per day _____ What Kind? _____
Daily caffeine Intake: # per day _____What Kind? _____
Have you ever used tobacco products? ☐ Yes ☐ No # per day _____ Year quit _____
Recreational drugs use? ☐ Yes ☐ No Currently using? ☐ Ye s ☐ No
Drug type: _____ Frequency: _____
Have you ever had an HIV Test? ☐ Yes ☐ No Date: _____
Typical Breakfast: _____ Typical Snacks: _____
Typical Lunch: _____How often do you exercise? _____
Typical Dinner: _____ What is your workout? _____

FAMILY HISTORY

	Age at Death	Age if Alive	General Health: Major Health Problems & Illnesses
Mother			
Father			
Brothers			
Sisters			

OTHER FAMILY HISTORY OF ANY OF THE FOLLOWING CONDITIONS: (Remember, most diseases that "run in the family" are not genetic, but rather reflect lifestyles or behavior patterns that we learn in our families)

	YES	NO		YES	NO		YES	NO		YES	NO
Osteoporosis	☐	☐	Diabetes	☐	☐	Alcoholism	☐	☐	Blood Clots	☐	☐
Heart Attack	☐	☐	Stroke	☐	☐	Cancer	☐	☐	TB	☐	☐
Thyroid Disease	☐	☐	Ulcers	☐	☐	Mental Illness	☐	☐	High Blood Pressure	☐	☐

PRESENT HEALTH CONCERNS (check all that apply)

CONSTITUTIONAL
- ☐ Recent loss of appetite weight gain/loss of 10 lbs or more in the past 6 months
- ☐ Fever
- ☐ Swelling in neck, armpit or groin
- ☐ Dizziness/Fainting

EYES, EARS, NOSE, THROAT
- ☐ Eye/Vision (blurred, halos, double, flashes)
- ☐ Wear glasses/contacts
- ☐ Ear/Hearing problems/ringing
- ☐ Sinus problems
- ☐ Hoarse voice
- ☐ Problems with teeth and gums
- ☐ Trouble swallowing
- ☐ Nasal D/C, Congestion
- ☐ Nose Bleeds
- ☐ Bleeding Gums

RESPERATORY
- ☐ Wheezing, Gasp to breathe
- ☐ Unusual sweating
- ☐ Chronic cough
- ☐ Persistent colds

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Pain or tightness in chest
- ☐ Racing heart/palpitations
- ☐ Shortness of breath
- ☐ Swollen ankles or feet
- ☐ Varicose veins

DIGESTION
- ☐ Excessive hunger/thirst
- ☐ Pain in stomach
- ☐ Persistent Nausea
- ☐ Rectal bleeding
- ☐ Heartburn/Indigestion
- ☐ Frequent Diarrhea
- ☐ Chronic constipation
- ☐ Rapid change in weight
- ☐ Vomited blood
- ☐ Stools black & tarry

SKIN
- ☐ Skin problems
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Sore that won't heal
- ☐ Bleeding problems

URINARY
- ☐ Painful urination
- ☐ Difficulty urinating
- ☐ Incontinence
- ☐ Frequency
- ☐ Blood in urine

MALE GENITAL
- ☐ Urine stream slow or weak
- ☐ Prostate problems
- ☐ Inability to ejaculate
- ☐ Painful testicles Swollen testis/penis
- ☐ Cancer or testicles
- ☐ Burning/discharge from penis

FEMALE GENITAL
- ☐ Heavy periods
- ☐ Painful cramps
- ☐ Bloating
- ☐ Spotting/irregular menses
- ☐ Vaginal discharge/itching
- ☐ Vaginal Dryness
- ☐ Breast lumps
- ☐ Uterine, ovarian, cervical cancer
- ☐ Nipple discharge
- ☐ Cysts in breast
- ☐ Breast cancer
- ☐ Abnormal PAP

___ Number of pregnancies

MUSCULOSKELETAL
- ☐ Pain in muscles
- ☐ Stiff joints/swollen joints
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Weakness

NEURO/PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Convulsions/Seizures
- ☐ Trembling or Shakiness
- ☐ Numbness
- ☐ Headaches more than 1x a week

HEALTH RISK FACTORS
- ☐ Diet to extreme
- ☐ Binge eat/vomit
- ☐ Wear seatbelt
- ☐ Wear bike/motorcycle helmet
- ☐ Memory/Concentration problems

HORMONAL
- ☐ Hot flashes/Night sweats
- ☐ Insomnia
- ☐ Fatigue
- ☐ PMS
- ☐ Irritability
- ☐ Food cravings
- ☐ Hair loss
- ☐ Dry skin/hair/nails
- ☐ Mood fluctuations
- ☐ Weight gain
- ☐ Headaches
- ☐ Depression
- ☐ Acne/oily skin
- ☐ Facial hair (women)

SEXUAL DYSFUNCTION
- ☐ Loss of sexual desire
- ☐ Loss of sexual sensation
- ☐ Pain with intercourse
- ☐ Inability to achieve orgasm