North Valley Family Medicine
6320 W Union Hills, Building B, Suite 2800,
Glendale, AZ 85308

(Please Print)

| Today's date: | MRN: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Street address: | City, State, Zip: | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|

| Email Address: | Home phone no.: ( ) | Mobile (if different): ( ) |
|---|---|---|

| Secondary Address(if Applicable) | City, State, Zip | Referring Physician: Primary Care Provider: | |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

Other family members seen here:

## RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

| Last Name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | |
|---|---|---|---|---|---|

| Street address: | City, State, Zip: |
|---|---|

| Email Address: | Home phone no.: ( ) | Mobile (if different): ( ) |
|---|---|---|

## PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Insurance Company: | Phone: ( ) | Policy# |
|---|---|---|

| Address of Insurance Company: | City: | State: | Zip Code: | Group# |
|---|---|---|---|---|

| Name of Insured: | Relationship to Patient: |
|---|---|

## SECONDARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Insurance Company: | Phone: ( ) | Policy# |
|---|---|---|

| Address of Insurance Company: | City: | State: | Zip Code: | Group# |
|---|---|---|---|---|

| Name of Insured: | Relationship to Patient: |
|---|---|

## IN CASE OF EMERGENCY

| Emergency Contact: | Relationship with Patient | Home phone no.: | Work Phone: |
|---|---|---|---|
| | | ( ) | ( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

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Name:_____ Age:_____ Today's Date: / /
Occupation:_____ Birthday: / /
☐Single ☐Separated ☐Widow(er) ☐Married ☐Divorced ☐Remarried Do you have a living will? YES / NO

List all persons who live in your household:

| | Name: | Relation | Age |
|---|---|---|---|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |

| | Surgery History | What Kind | Year |
|---|---|---|---|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |

**HEALTH HISTORY OF YOURSELF AND BLOOD RELATIVES**

| | You | Date | Relative | Relationship |
|---|---|---|---|---|
| Asthma | | | | |
| Cancer type | | | | |
| Chronic Back Pain | | | | |
| Depression/Anxiety | | | | |
| Developmental Delay | | | | |
| Diabetes | | | | |
| Heart Disease | | | | |
| High Blood Pressure | | | | |
| High Cholesterol | | | | |
| Migraines | | | | |
| Obesity | | | | |
| Thyroid Disorder | | | | |
| Seasonal Allergies | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |

| | Hospitalizations for What Reasons | Month/Year |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |

| | Allergies to Medication | Reaction |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |

| | Medications | Dose | Times per day |
|---|---|---|---|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |
| 6) | | | |
| 7) | | | |

**HEALTH MAINTAINENCE**

| When was your Last: | Date | |
|---|---|---|
| Cholesterol Test | / / | |
| General Bloodwork | / / | |
| Eye Exam | / / | |
| Dental Exam | / / | |
| Tetanus Shot | / / | |
| Pap Smear | / / | |
| Colonoscopy (age 50+) | / / | |
| Rectal Exam (age 50+) | / / | |
| Bone Density Scan (Woman 50+) | / / | |
| Mammogram (Woman 40+) | / / | |
| PSA test (Men 50+) | / / | |

| | | | |
|---|---|---|---|
| Do you eat well balanced meals every day? | | | Yes / No |
| Do you take vitamins or supplements? | | | Yes / No |
| What Kind? | | | |
| Exercise Regular? Yes / No | How Often? | / per week | |
| What form of exercise to you do? | | | |
| Do you smoke? | Yes / No / Former | How Much? | |
| Drink alcohol? | Yes / No / Former | How Much? | |
| Do you use recreational Drugs? | Yes / No / Former | | |
| FEMALES ONLY | | | |
| Date of last menstrual period | / / | | |
| Method of contraception | | | |
| Number of times pregnant | / / | | |
| Number of births that were | Full Term | | |
| Preterm | | Abortions | |
| Miscarriages | | Vaginal Deliveries | |
| Cesareans | | | |

North Valley Family Medicine

# FINANCIAL AGREEMENT

**Thank you for choosing North Valley Family Medicine as your health care provider**.
We are committed to providing you with the best possible care, and we will be pleased to discuss our professional fees with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

As a courtesy to our patients, we will bill your insurance company; however, you are financially responsible regardless of insurance coverage. Although we will help as much as possible, you are responsible for the timely payment of your account.

Contracts with insurance companies vary. We can let you know if we are contracted with your insurance carrier, but it is your responsibility to verify with your specific plan. Please verify NVFM is covered within your specific benefit plan. It is also patient responsibility to know your plan benefits such as; Exclusions, Pre-existing Conditions, Deductibles, Co-insurance and Non-Covered Charges. We do not bill third party insurances such as auto, home, or workman's compensation. If you are unsure of your insurance benefits, please contact your carrier for clarification of your coverage.
It is your responsibility to notify our office if there is a change of name, insurance coverage, address and/or phone number. If for any reason you do not update your information in a timely manner and it causes a claim denial, you will be responsible for the full balance of that claim.

***CO-PAYS/DEDUCTABLES***
Payment for all deductibles and/or co-pays is required at the time of visit. You are responsible for any unpaid balance on your account. Our office accepts cash, checks and debit/ credit cards. Any return checks is subject to a $25.00 return check fee.

***COLLECTIONS/BAD DEBT***
Any payment arrangement will be at the discretion of North Valley Family Medicine. In the event that your account is turned over for collections, you will be responsible for a $30.00 collection fee and any fees acquired by our collection agency.
If any signer is entitled to insurance benefits of any type whatsoever under any policy insuring the patient of/from any other party, the benefits are hereby assigned to North Valley Family Medicine for application to the patient's bill. ***However, it is understood that the undersigned and patient are primarily responsible for payment of the patient's bill in any situation.***
By signing this agreement, you are indicating that you have read and understand the above financial policy.

_____

(**Print**)Patient Name DOB Date

_____

Signature of Patient/Guardian/Other Party Date

_____

Witness Relationship to Patient Date

North Valley Family Medicine

# RELEASE OF TEST INFORMATION

***Please read document before filling out form****

I, _____, give my consent to the staff of North Valley Family Medicine to replay any lab, radiology testing or any other imperative information to including but not limited to referral information, medication refills, ect:

Please Check the following:

| YES | NO | | | | | |
|---|---|---|---|---|---|---|
| ___ | ___ | SELF ONLY (we can only leave information with you) | | | | |
| ___ | ___ | Answering machine, voicemail, or any other answering server device | | | | |
| ___ | ___ | _____ | (Name) | _____ | (Relationship) | |
| ___ | ___ | _____ | (Name) | _____ | (Relationship) | |

**Best Telephone number to contact me is at:**_____

| Patient Print Name | If patient is a minor, please have guardian sign | Date |
|---|---|---|
| Patient Signature | If patient is a minor, please have guardian sign | Date |

Notice: By signing this form, you understand the policy

In accordance with the federal HIPPA regulations, we can only release information to persons or leave messages on alternative sources (i.e. answering machine, voicemail) indicated on the signed, original form. We cannot accept a verbal authorization to leave test information to persons or sources not listed on the form. You may update your release of test information at any time. If you need to update any information, a new Release of Test information for must be filled out and signed. Thank you.

North Valley Family Medicine

# PHARMACY INFORMATION

Patient Name: DOB:

Pharmacy Name:

Location (Cross streets or address)

Phone Number (If known)