North Valley Family Medicine

18699 N 67th Avenue
Glendale, AZ 85308
(623) 322-4991

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	REFERRING PHYSICIAN	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

Emergency Contact: ______________ Relationship to Patient: ______________ Phone: ______________

Patient Nickname (if any): ______________ How Did You Hear About Our Practice? ______________

By signing below I acknowledge that the office's Notice of Privacy Practices has been made available to me.

SIGNATURE OF PATIENT/GUARDIAN ______________ DATE ______________

North Valley Family Medicine

NAME ________________ AGE ________ TODAY'S DATE ________________

OCCUPATION ________________ BIRTH DATE ________________

☐ Single ☐ Separated ☐ Widow(er) ☐ Married ☐ Divorced ☐ Remarried DO YOU HAVE A LIVING WILL? Y/N

List all persons who live in your household:

	NAME	RELATION	AGE
1)			
2)			
3)			
4)			

HEALTH HISTORY OF YOURSELF AND BLOOD RELATIVES

Have you or a family member had the following:

	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:				

HEALTH MAINTAINENCE

When was your last:

Cholesterol test ________________

General bloodwork ________________

Eye exam ________________

Dental Exam ________________

Tetanus Shot ________________

Pap Spear ________________

Colonoscopy (50 and older) ________________

Rectal exam (50 and older) ________________

Bone density scan (Women 50 or older) ________________

Mammogram (Women 40 or older) ________________

PSA test (Men 50 or older) ________________

SURGERY HISTORY: WHAT KIND YEAR

1) ________________
2) ________________
3) ________________
4) ________________
5) ________________

HOSPITALIZATIONS: (other than operations or childbirth)
FOR WHAT REASON MONTH/YEAR

1) ________________
2) ________________
3) ________________

ALLERGIES TO MEDICATION REACTION

1) ________________
2) ________________
3) ________________

MEDICATIONS (DOSE/TIMES PER DAY)

1) ________________
2) ________________
3) ________________
4) ________________
5) ________________
6) ________________
7) ________________
8) ________________

HABITS

Do you think you eat well balanced meals everyday? Yes / No

Do you take vitamins or supplements? Yes / No

What kind? ________________

Exercise regularly? Yes / No How often? ________________

What form of exercise do you do? ________________

Do you smoke? Yes / No / Former How much? ________________

Drink alcohol? Yes / No / Former How much? ________________

Do you use any 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

John W. Ellis, D.O.
Board Certified Family Physician

Tanya B. Ellis, M.D.
Board Certified Family Physician

Don R. Middleton, D.O.
Board Certified Family Physician

Deborah A. Solomon, D.O.
Board Certified Family Physician

FINANCIAL AGREEMENT

Thank you for choosing North Valley Family Medicine as your health care provider.

We welcome you and are committed to providing quality medical care.

Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our staff if you have any questions.

It is your responsibility to be aware of your benefits. Exclusions, pre-existing conditions, and terminated health benefits may nullify insurance coverage and transfer the financial obligation to the responsible party. Plan specifics, such as any deductibles, co-insurance, or non-covered charges, are the responsibility of the patient to know. <u>Our office sees hundreds of patients and it is impossible for everyone on our staff to know every single patient's detailed insurance coverage.</u> *If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of your coverage.*

This office is not in the practice for changing or re-coding claims once they have been billed. This constitutes fraud, and will not be tolerated.

Payment is due prior to the time of service. You are responsible for any unpaid balance on your account. Our office accepts cash, checks, debit cards, and Visa / MasterCard. There is a $25 returned check fee.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence, and/or phone number.

I agree to make financial arrangements satisfactory to North Valley Family Medicine for payment in return for services provided. If the account is sent to a Collection Agency for collection, I agree to pay reasonable fees and the collection expenses. The amount of the Collection's fees shall be established by North Valley Family Medicine dependant on what Collection Agency chosen. A delinquent account may be charged interest at the legal rate.

If any signer is entitled to applicable benefits of any type whatsoever under any policy of insurance insuring patient of from any other party, the benefits are hereby assigned to North Valley Family Medicine for application on the patient's bill. However, *it is understood that the undersigned and patient are primarily responsible for payment of the patient's bill.*

In rendering treatment, North Valley Family Medicine is relying on the above agreement to ensure payment of the account.

Patient Name ______ Signature of Patient/Guardian/Other Party ______ Date ______

Witness ______ Relationship to Patient ______ Date ______

Arrowhead Physicians Plaza ❖ 18699 N. 67th Ave. Suite 280 ❖ Glendale, AZ 85308 ❖ Office: 623-322-4991 ❖ Fax: 623-322-9568

North Valley Family Medicine

John W. Ellis, D.O.
Board Certified Family Physician

Tanya B. Ellis, M.D.
Board Certified Family Physician

Don R. Middleton, D.O.
Board Certified Family Physician

Deborah A. Solomon, D.O.
Board Certified Family Physician

RELEASE OF TEST INFORMATION

Please read document before filling out form

I, ______________________, give my consent to the staff of North Valley Family Medicine to relay any lab, radiological testing or any other imperative information to including but not limited to referral information, medication refills, etc:

Please check the following:

YES	NO	
___		SELF ONLY (we can only leave information with you)
___	___	Answering machine, voicemail or any other answering service device
___	___	______________________ (name) ______________ (relationship)
___	___	______________________ (name) ______________ (relationship)

Best telephone number to contact me is at: ______________________

Patient/Guardian *Signature* ______________________

Patient/Guardian Print Name ______________________

NOTICE: By signing this form, you understand the policy

In accordance with federal HIPPA regulations, *we can only release information to persons or leave messages on alternative sources (i.e. answering machine, voicemail) indicated on this 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 form must be filled out and signed. Thank you.

North Valley Family Medicine

John W. Ellis, D.O.
Board Certified Family Physician

Tanya B. Ellis, M.D.
Board Certified Family Physician

Don R. Middleton, D.O.
Board Certified Family Physician

Deborah A. Solomon, D.O.
Board Certified Family Physician

Pharmacy Information

Pharmacy Name:______________________________________

Location:______________________________________
(Cross streets or address)

Phone Number:______________________________________
(If known)

rrowhead Physicians Plaza ❖ 18699 N. 67th Ave. Suite 280 ❖ Glendale, AZ 85308 ❖ Office: 623-322-4991 ❖ Fax: 623-322-9568

North Valley Family Medicine

John W. Ellis, D.O. Board Certified Family Physician | Tanya B. Ellis, M.D. Board Certified Family Physician | Don R. Middleton, D.O. Board Certified Family Physician | Deborah A. Solomon, D.O. Board Certified Family Physician

MEDICAL RECORDS RELEASE

This release Expires 90 days from the date of signature or upon patient's written request

Patient's Name: ______________________ Date: ______________

Social Security #: ______________________ Date of Birth: ______________

Home Phone: ______________________ Daytime Phone: ______________

Address: ____

To:
North Valley Family Medicine
☐ Tanya Ellis, MD Deborah Solomon, DO ☐
Don Middleton, DO ☐
18699 North 67th Avenue, Suite 280
Glendale, AZ 85308
Fax: (623)322-9568 Phone: (623)322-4991

From: ______________________
____
____
____

*******If faxing records DO NOT fax over 25 pages!*******

Please initial only ONE of the appropriate boxes to indicate which records you wish to be released and may be charged for:

____ Records generated in the office only (including x-rays, electrocardiograms, old records, outside lab results) If no box is initiated, this option will be used.

____ Records generated in the office only (not including x-rays, electrocardiograms, old records, outside lab results, which may incur an additional charge).

____ Only those records pertaining to (specify types and dates): ______________________

Patient/Responsible Party Signature: ______________________ Date ____________

******************PLEASE READ SIGN BELOW******************

I understand that a separate, expressed consent is required to release sensitive healthcare information in my record, and I specifically request that ______________________ (name of physician or facility) release any medical information pertaining to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

Patient/Responsible Party Signature: ______________________ Date ____________

Witness: ______________________ Date: ______________

Revised 9-2-2008