



# NORTERRA

FAMILY MEDICINE

## PATIENT INTAKE AND MEDICAL INFORMATION

### PATIENT INFORMATION:

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

DOB: \_\_\_\_\_ GENDER:  M  F SSN (required): \_\_\_\_\_

Marital Status:  Divorced  Married  Separated  Single  Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (H): \_\_\_\_\_ Phone (C): \_\_\_\_\_ Phone (W): \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

Primary Language Spoken in your Household: \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  Native Hawaiian  Black or African American

White  Hispanic  Other Race  Other Pacific Islander  Refused to Report

Ethnicity:  Hispanic or Latin  Asian  Not Hispanic or Latin  Refused to Report

Do you have advanced directives in place?	(Please Circle) Yes or No
Please bring copies of advanced directives to your	Appointment for your chart.
Medical Power of Attorney? Yes / No	Name of person(s) listed:
Do not Resuscitate? Yes/No	Do you have a Living Will? Yes/No

### FINANCIALLY RESPONSIBLE INDIVIDUAL (If different than above):

Name of Insured:	Relationship to Patient:	
SSN:	DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Phone (H):	Phone (W):	
Address:		

### PRIMARY INSURANCE:

Insurance Company:	Group #:	SSN:
Name of the insured:	Policy ID:	DOB:
Address of the insured:		

### SECONDARY INSURANCE:

Insurance Company:	Group #:	SSN:
Name of the insured:	Policy ID:	DOB:
Address of the insured:		

\*\*\*Please note that if you have a secondary insurance and it is not identified, the patient will be financially responsible for any claims not paid.



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## Back Office Use

Patient Name: \_\_\_\_\_

### Pharmacy:

(Name & Location): \_\_\_\_\_ Phone: \_\_\_\_\_

### Current Medications:

Medication & Strength:	Frequency:	Medication & Strength:	Frequency:
1.)		6.)	
2.)		7.)	
3.)		8.)	
4.)		9.)	
5.)		10.)	

### Medical History:

Have you ever had, or do you currently have, any of the following medical problems? (Please Check)		
<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> Emphysema / COPD	<input type="checkbox"/> Immune Disorders Type: _____
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Arthritis Type: _____	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Irritable Bowel Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bulging Disc	<input type="checkbox"/> Heart Disease Type: _____	<input type="checkbox"/> Migraines
<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Disorder
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Sugar	<input type="checkbox"/> Stroke / CVA
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Urinary Tract Disorders Specify: _____
<input type="checkbox"/> Eczema	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Uterine or GYN Problems Specify: _____
<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Abnormal Mammogram	<input type="checkbox"/> Other: _____

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Phoenix, AZ 85085

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**Back Office Use**

Patient Name: \_\_\_\_\_

**Allergies/ Intolerance** (Medication or Supplements):

<b>Agent /Substance</b>	<b>Reaction:</b>	<b>Agent /Substance:</b>	<b>Reaction:</b>
1.)		6.)	
2.)		7.)	
3.)		8.)	
4.)		9.)	
5.)		10.)	

**Surgical History:**

<b>Date:</b>	<b>Surgery:</b>



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Patient Name: \_\_\_\_\_

### Hospitalization:

Date:	Reason:	Date:	Reason:

### Family History:

Type Of Disease	Yes or No	Relationship	Maternal/Paternal
Diabetes:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Children	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
High Blood Pressure:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Children	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
High Cholesterol:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Children	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Heart Disease: Type: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Children	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Cancer: Type: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Children	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Chronic Mental Illness: Type: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Children	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal
Other: _____ Type: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Children	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal



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Patient Name: \_\_\_\_\_

### Social History:

<b>Tobacco Section:</b>	
Do you currently use Tobacco:	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how much do you currently smoke (packs/ cigarettes a day) or chew:	How many <b>Cigarettes a day:</b> _____ How many <b>Packs a day:</b> _____ How much <b>Chewing Tobacco a day:</b> _____
Did you use Tobacco in the past:	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, when did you quit:	
<b>Drug Section:</b>	
Do you use any <b>Illicit Drugs:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, which drug(s):	<input type="checkbox"/> <b>Marijuana</b> <input type="checkbox"/> <b>Cocaine</b> <input type="checkbox"/> <b>Meth.</b> <input type="checkbox"/> <b>Heroin</b> <input type="checkbox"/> <b>Other:</b> _____
How much per week:	
<b>Alcohol Section:</b>	
Do you drink <b>Alcohol:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how much do you drink per day:	<input type="checkbox"/> 1 or 2 drinks <input type="checkbox"/> 3 or 4 drinks <input type="checkbox"/> 5 or 6 drinks <input type="checkbox"/> 7 to 9 drinks <input type="checkbox"/> 10 or more drinks
<b>Caffeine Section:</b>	
Do you drink Caffeine:	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how many cups/ ounces per day:	<input type="checkbox"/> None <input type="checkbox"/> 1-2 cups per day <input type="checkbox"/> 2-3 cups per day <input type="checkbox"/> 3-4 cups per day <input type="checkbox"/> more than 4 cups per day
<b>Miscellaneous Section:</b>	
How would you describe your <b>Diet:</b>	<input type="checkbox"/> <b>Healthy &amp; Balanced</b> <input type="checkbox"/> <b>Average</b> <input type="checkbox"/> <b>Poor</b>
Do you currently <b>Exercise:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how many days per week do you exercise:	
<b>House Hold Section:</b>	
Are your Married, Separated or Single: How many children do you have:	<input type="checkbox"/> <b>Married</b> <input type="checkbox"/> <b>Separated</b> <input type="checkbox"/> <b>Single</b> <b>Number of Children:</b> _____



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## Back Office Use

Patient Name: \_\_\_\_\_

### GYN History (Female Only):

Symptoms/ Question	Notes/ Dates
Periods:	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular
Sexual Activity	<input type="checkbox"/> YES <input type="checkbox"/> NO
Last Mammogram:	<b>Date:</b> _____
Last Pap Smear:	<b>Date:</b> _____
Abnormal Pap Smear:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date of last Period:	<b>Date:</b> _____
Menopause Began at Age:	<b>Age:</b> _____

### O/B History (Female Only):

Symptoms/ Question	Notes/ Dates
<b>Gravida</b> ( Number of Pregnancies):	
<b>Para</b> (Number of Viable Births):	
Stillbirth(s):	
Miscarriage(s):	
Abortion(s):	
C-Section(s):	



**Back Office Use**

Patient Name: \_\_\_\_\_

**Immunizations:**

<b>Vaccines</b>	<b>Yes or No</b>	<b>Date</b>
Tetanus/ Tdap:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Pneumococcal:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Influenza:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Shingles (Zostavax)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	

**Preventative Medicine:**

<b>Screening Test</b>	<b>Yes or No</b>	<b>Date</b>
Vision Screen:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Osteoporosis Screen:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Colorectal Cancer Screen:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Last Cholesterol Lab Test:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Last Glucose (blood Sugar) Lab Test:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Last Hemoglobin A1c Lab Test:	<input type="checkbox"/> YES <input type="checkbox"/> NO	

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**RELEASE OF TEST INFORMATION & PATIENT COMMUNICATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I request and give consent to Norterra Family Medicine and/or its staff to relay any and all communications regarding my lab results, radiological testing, referral information or any other pertinent information to be handled in the following manner.

**WRITTEN COMMUNICATION:**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**VERBAL COMMUNICATION:**

Phone Number: \_\_\_\_\_ May we leave a detailed message?  Yes  No

Phone Number: \_\_\_\_\_ May we leave a detailed message?  Yes  No

Please provide my medical information to individual(s) other than myself or state NONE.

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**APPOINTMENT REMINDERS:**

Please indicate what your preferred contact is for your Appointment Reminders:

**CALL** – Phone Number: \_\_\_\_\_ (Home, Cell, Work)

**TEXT** – Phone Number: \_\_\_\_\_

**EMAIL** – Email Address: \_\_\_\_\_

**PATIENT PORTAL:**

Please indicate if you would like NFM to establish Patient Portal access:  Yes  No

Email Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_





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**OFFICE & FINANCIAL POLICY**

Thank you for choosing Norterra Family Medicine (NFM) for your healthcare needs. Our Office and Financial Policy is an important part of your healthcare. Please review the following Office and Financial Policy.

1. **OFFICE & PHONE HOURS:** Our normal office hours are Monday – Thursday from 8:00 a.m. – 5:00 p.m. and Fridays from 8:00 a.m. – 12:00 p.m. Phones will be answered during this time with the exception to 12:00 p.m. – 1:00 p.m., while the practice is closed for lunch.
2. **APPOINTMENTS:** Patient appointments are scheduled Monday & Thursday from 7:00 a.m. – 5:00 p.m., Tuesday & Wednesday from 8:00 a.m. – 5:00 pm and Friday's from 8:00 a.m. – 12:00 pm.
3. **ON-TIME:** All attempts are made by our office to keep your scheduled appointments on time, however, unforeseen issues may come up that may cause delays and we apologize, in advance, when this occurs, however, each of our patients are important to us and are given the attention that is needed to address each patient's medical needs.
4. **CANCELLATIONS/NO SHOWS:** NFM offers Appointment Reminder Calls as a **courtesy** to our patients. If you arrive more than 15 minutes late for your scheduled appointment, we may ask that you reschedule your appointment. If you No Show an appointment or Cancel and do not notify us at least 24 hours prior to your scheduled appointment, you will be charged \$35.00. Any early or extended appointments missed will be charged \$60.00.
5. **MEDICATIONS:** We do not prescribe any medications over the phone. You must be seen by a provider in order to receive a prescription of any nature. For any medication refills, please contact your pharmacy first, however, if you request a refill and leave a message with one of our MA staff then please allow a minimum 72 hours' notice. For requests after 4:00 p.m. on Fridays, these requests will be addressed the following business day. Please note, our providers do not refill medications after-hours for ANY reason, this includes pain medications. It is your responsibility to keep track of the level of your medications and call our office during normal business hours to request medication refills.
6. **AFTER HOURS ON-CALL SERVICES:** Norterra Family Medicine does not have after hour's on-call services between the hours of 5:00 p.m. and 8:00 a.m. During this time period, if you require urgent medical services, we recommend that you proceed directly to your nearest Emergency Department or Urgent Care Center. We have conveniently placed the names and phone numbers of some of these facilities on our website.
7. **TREATMENT OF MINORS:** Patients under the age of 18 must be accompanied by a responsible adult or have written permission, for treatment, from a parent or guardian.
8. **PATIENT PORTAL:** NFM offers a Patient Portal service for patients to receive non-urgent lab, radiology, and other diagnostic test results, request appointments, medication refill, and referrals, and contact NFM staff for billing and non-urgent medical questions. This service is not intended to treat or obtain care for urgent or emergency conditions. Patient Portal is offered through NFM's electronic medical record vendor, e-CW ®. Both, NFM and e-CW maintains this portal utilizing appropriate technical safeguards and encryption as required by HIPAA. NFM will not have any access to your portal user ID and password due to HIPAA regulations. It is your responsibility to keep your portal user ID and password secure.



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9. **LABORATORIES:** Norterra Family Medicine houses a Laboratory in our office for our patient’s convenience and we will automatically send lab testing to this lab unless otherwise directed by you **before the draw**. If your insurance company requires the use of a specific laboratory, you must notify the phlebotomist in order to ensure your blood is sent to the correct lab. If you are unsure, we suggest that you contact your insurance carrier **prior** to having any labs drawn to ensure your labs are sent to the correct laboratory. Please note that there may be some labs ordered by our providers that are not a covered benefit on your insurance plan as our providers order what they deem as medically necessary and not based on insurance coverage. The lab will bill your insurance company directly for any lab testing done in our office. It is your responsibility to provide your current insurance and billing information to the Phlebotomist. If you receive any bill(s) from the lab for any lab testing done in our office, please contact the lab directly, which is listed on the invoice, and they will contact our office for assistance, if needed, as NFM does not have access to lab Patient Billing. If you experience any issues related to the service you received from the phlebotomist, please make sure you tell our check-out desk immediately.
  
10. **INSURANCE PARTICIPATION:** Although NFM is contracted with most insurance companies, it is **your** responsibility to make sure that our physician is an in-network provider in your specific plan and knowing your insurance coverage and benefits. The qualifying TIN’s that you should verify is 26-2697154. We ask that you contact your insurance company directly if you have any questions regarding your coverage. NFM is not contracted with any State-funded plans, including Medicaid or AHCCCS.
  
11. **BILLING:** I request and authorize NFM to bill my insurance company on my behalf. NFM agrees to invoice my insurance company in a timely manner and will assist in any way reasonably to help get claim(s) paid by my insurance. I authorize NFM to release the necessary information in order to complete and process my claim(s). At times, your insurance may request that you supply certain information to them directly. It is your responsibility to comply in a timely manner as well. Please be aware that the balance of your claim(s) is your responsibility, whether or not your insurance company pays your claim(s).
  
12. **CO-PAYS, DEDUCTIBLES, & PAYMENTS:** I agree to pay my co-pay, coinsurance, and deductible **AT TIME OF SERVICE**. We collect for the office visit portion **ONLY**, and will bill your insurance for all services rendered during the appointment. Any additional services (EKG, Urinalysis, etc) provided on the date of service that your insurance determines patient responsibility, will be billed to you after NFM has received payment by your insurance company for your claim(s). If you are **CASH PAY** and do not have insurance, payment for **ALL** services rendered will should be collected **AT TIME OF SERVICE**.
  
13. **“NON-COVERED” SERVICES:** I understand that some, and perhaps all, of the services I receive may not be covered by my insurance or deemed “not medically necessary or considered experimental” by my insurance company. I agree to pay for any services that my insurance determines as “non-covered.”
  
14. **UPDATES & COVERAGE CHANGES:** Our staff may ask you to verify your insurance and billing information at each and every visit and may request a copy of your insurance card each time. Current information is crucial in order for NFM to obtain timely payment from your insurance information. We ask that you notify us as soon as possible if your medical coverage changes so we can make the appropriate changes. If your insurance company does not pay a claim within 90 days, the full balance will be billed to you.
  
15. **RETURNED CHECKS:** Any returned checks for Non-Sufficient Funds will be charged a processing fee of \$45.00.

**I hereby acknowledge that I have reviewed and understand Norterra Family Medicine’s Office & Financial Policy.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

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I understand how medical information about me may be used and disclosed, and how I can get access to my information as described under the **HIPAA Notice**. At any time, I can request a copy of the updated HIPAA Notice from NFM and it is also available on our website.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_