Patient Intake Form - Annual

Patient Name: ____________________________________ Preferred Name: ________________________________

Address: ____ DOB: _____________

Phone Number: __________________________________ Email: ____

Do we have your consent to: TEXT ☐ Yes ☐ No CALL ☐ Yes ☐ No EMAIL ☐ Yes ☐ No

Marial Status Single ☐ Married ☐ Divorced ☐ Widow ☐	Male ☐ Female ☐	Gender Identity:
Hispanic or Latino: Yes ☐ No ☐	Race:	

Emergency Contact Name:	Relation::	Phone:
To whom may we disclose your health information? Appointment times, test results, billing information, etc	Name:	Phone:

Primary Insurance	
Policy Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	
Relationship to Subscriber	

Secondary Insurance	
Policy Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	
Relationship to Subscriber	

FINANCIAL POLICY AND GOOD FAITH ESTIMATE REQUESTS

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, front you. If your insurance company requests a refund of payments made, you will be responsible for the amount refunded to your insurance company. In the event your company establishes an internal usual and customary fee scheduled, you will be responsible for the remaining difference. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the payment to Morgan Family Medicine, LLC.

Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter

If you do not have insurance or if your insurance is considered Out of Network with your insurance provider, you are encouraged to ask for a Good Faith Estimate and one will be provided to you, in accordance with The No Surprise Billing Act of 2022.

Morgan Family Medicine LLC does not bill Workman’s Compensation insurances.

By signing below, I understand and agree that my account if paid within 90 days of my discharge will be interest free and after 90 days my account will be subject to a 12% interest APR. If I fail to make any payments for which I am responsible

in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

GENERAL CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent and authorize Morgan Family Medicine and all its providers and ancillary medical personnel to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which my specific informed consent is not otherwise required. I understand that certain procedures will require specific informed consent, and that MFM will provide me with information and forms prior to such procedures.

CLINIC POLICIES AND PRACTICES

By INITIALLING below, I agree:

______ I agree and understand that other patients will be receiving medical care during my visit and may overhear information regarding my plan of care.

______ I agree that a Registered Nurse or Medical Assistant or a nursing student or a medical assistant student may assist in my care.

______ I agree that I must check in and check out at each visit and understand that subsequent visitors may have the opportunity to see my name.

______ I agree that Morgan Family Medicine may share medical information with the Idaho Data Exchange for medical data sharing.

______ I agree with Morgan Family Medicine's scheduling policy – I will attend all scheduled appointments, or I will cancel by providing 24-hour notice. I understand there is a $35 fee for all appointments tha I do not attend unless it is cancelled or rescheduled with 24+ hours' notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of Morgan Family Medicine's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI") as well as clinic specific polices. I understand that MFM has the right to change its Notice of Privacy Practices and/or clinic specific policies from time to time and that whenever an important change is made, MFM will post a new notice in its office. I may contact MFM at any time to obtain a current copy of the Notice of Privacy Practices.

☐ ***CHECK HERE IF PATIENT IS A MINOR OR NOT THEIR OWN GUARANTOR***

Signature: ______________________________________ Today's Date: ___________________________________

If applicable:
Representative's Name: ___________________________ Relationship to Patient: ___________________________

Authorization for Release of Patient Health Information

I, ________________________________, DOB ________________, authorize **Morgan Family Medicine** to release and/or request my medical records to/from all healthcare facilities.

Information to be Disclosed: (Please check all boxes that apply)

- ◯ **All Medical Records**
- ◯ Lab Results
- ◯ ER Reports
- ◯ Imaging Reports
- ◯ Office/Progress Notes
- ◯ Initial Evaluation
- ◯ Discharge Summary
- ◯ Operative Reports
- ◯ Other: ____

These records may include:

- HIV/Aids testing, test results, treatment and related information including high risk behavior
- Drug and/or alcohol diagnosis, treatment, test results and reports and referral information
- Mental health treatment, test results, reports including psychological and psychiatric studies

Requested Dates of Service

- ◯ 2 years prior from last date seen
- ◯ Specific dates __________ to __________

Reason for Disclosure:

- ◯ Continuation of Care
- ◯ Change of Insurance or Physician
- ◯ Other: ______________________

I understand that my signature is voluntary and if I refuse to sign this form it may result in the provider being unable to treat me fully without relevant medical history. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. This authorization will expire one (1) year from the date signed.

Today's Date: __________________________

I have read the above foregoing Authorization of Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

____ Relationship: Self Other: __________________

Printed Name of Patient or Representative

____

Signature of Patient or Patient's Representative

Medical Screening Intake Form

Name:	Date of Birth:
Primary Pharmacy:	Secondary Pharmacy:
Reason for Visit:	
Allergies (food, environment, medications):	

Personal Past Medical History Select ALL that apply to you.

Abuse/Domestic Violence	☐	GI Problems/GERD	☐
ADD/ADHD	☐	Gout	☐
AIDS/HIV	☐	Head Injury/Concussion	☐
Alcoholism/Drug Abuse	☐	Headaches/Migraines	☐
Allergies/Hay Fever	☐	Heart Arrhythmias/Murmur	☐
Alzheimer's/Dementia	☐	Heart Disease/Coronary Artery Disease	☐
Anemia/Blood Disorder	☐	Hepatitis	☐
Anxiety Disorder/Panic Attack	☐	High Cholesterol	☐
Arthritis/Joint Pain	☐	Hormone Problems	☐
Asthma/COPD	☐	Hyper or hypo-thyroidism	☐
Autism Spectrum Disorder/Developmental Delay	☐	Hypertension	☐
Behavioral Disorder	☐	IBS/Diverticulitis	☐
Birth Defects or Congenital Disease	☐	Infertility	☐
Bladder or Kidney Problems	☐	Kidney Stones	☐
Breast Problem	☐	Liver Disease	☐
Cancer ***TYPE:*** ______________________________	☐	Menopausal Symptoms	☐
Chest Pain/Angina	☐	Menstrual Problems/Endometriosis	☐
Chronic Pain	☐	Obesity/Weight Issues	☐
Colitis/Crohn's	☐	Osteoporosis/Bone Problems	☐
Congestive Heart Failure (CHP)	☐	Pulmonary Embolism/Deep Vein Thrombosis	☐
Constipation	☐	Rectal Bleeding	☐
Depression/Bipolar Disorder	☐	Seizures/Epilepsy	☐
Diabetes	☐	Sexual Disfunction/Decreased Libido	☐
Difficulty Swallowing	☐	Sexually Transmitted Infections	☐
Dizziness/Fainting	☐	Shortness of Breath/Oxygen Dependence	☐
Ear or Hearing Problems	☐	Skin Problems	☐
Eating Disorder	☐	Stroke/TIA	☐
Eczema/Psoriasis	☐	Suicide Attempts/Self Harm	☐
Fatigue	☐	Urinary Incontinence/Chronic UTIs	☐
Fibromyalgia/Muscle Pain	☐	Vision or Eye Problems	☐

Medical Screening Intake Form

List any SURGERIES or conditions for which you have been HOSPITALIZED

1.)	4.)
2.)	5.)
3.)	6.)

OTHER Medical History not listed above?

1.)	4.)
2.)	5.)
3.)	6.)

List any Medications you are currently taking. Please include dosage and over the counter medications.

1.)	5.)	9.)
2.)	6.)	10.)
3.)	7.)	11.)
4.)	8.)	12.)

SOCIAL HISTORY

Diet: ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Low Carb ☐ Cardiac ☐ Diabetic ☐ Regular
Any Dietary Restrictions? ☐ No ☐ Yes ____
Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
How many times per week do you exercise? ____
What type of sporting activities do you participate in? ______________________________

Relationship ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Other
Sexually Active ☐ Yes ☐ No How many children do you have? __________________

Smoking Status: ☐ Never smoked ☐ Former Smoker ☐ Current every day ☐ Current some days
Vape/E-cigarette: ☐ Never used ☐ Former User ☐ Current every day user
Smokeless Tobacco: ☐ Never Used ☐ Former User ☐ Current snuff user ☐ Current chew user
☐ Current moist powered tobacco user
Alcohol Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Use of illicit or recreational drugs? ☐ No ☐ Yes
Caffeine consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Do you have an advanced directive? ☐ No ☐ Yes

Do you participate in social media? ☐ No ☐ Yes

Do you wear a helmet while biking? ☐ No ☐ Yes

Do you use a seatbelt in the car? ☐ No ☐ Yes

Do you feel stressed (tense, restless, nervous, anxious, or unable to sleep at night?
☐ Not at all ☐ Only a little ☐ To some extent ☐ Rather much ☐ Very much

MORGAN FAMILY MEDICINE

Medical Screening Intake Form

FAMILY HISTORY

☐ Check box if you are adopted and do not know your family medical history

Condition	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	Paternal Uncle	Paternal Aunt	Maternal Uncle	Maternal Aunt	Other
Alcohol or Drug Abuse													
Anemia/Bleeding Disorder													
Angina													
Cataracts/Glaucoma													
COPD/Asthma													
Crohn's/Colitis													
Depression/Anxiety													
Diabetes													
Epilepsy (seizures)													
Headaches/Migraines													
Heart Problems/Murmur													
Hepatitis													
High Blood Pressure													
High Cholesterol													
HIV/AIDS													
Kidney Stones/Kidney Disease													
Leukemia													
Pancreatitis													
Psoriasis/Eczema													
Pulmonary Embolism													
Rheumatic Fever													
Stomach Ulcer/GERD													
Stroke/TIA													
Thyroid Disorder													
Tuberculosis													
Cancer													
Other Medical Conditions													