Patient Intake Form - Annual

Patient Name: ___________________________________ Date: _______________________

Preferred Name: _______________________________ DOB: _______________________

Address: ____

Phone Number: _________________________________ Email: ____

Do we have your consent to: (circle yes or no) TEXT: Yes No LEAVE DETAILED MESSAGE: Yes No EMAIL: Yes No

Marial Status: Single ☐ Married ☐ Divorced ☐ Widow ☐ Legally Separated ☐	Male ☐ Female ☐	Gender Identity:
Hispanic or Latino: Yes ☐ No ☐	Race:	Preferred Language:
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, from 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 insurance.

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.

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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 with Morgan Family Medicine's scheduling policy –I understand there is a $35 fee for all appointments I do not attend unless it was canceled or rescheduled with 24+ hours' notice. This will include but is not limited to tardiness, or fully missed appointments, after the third strike you may be discharged from the clinic.

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

Name of Guarantor: ____ DOB: ______________________

Address: ____

Phone Number: ______________________________ Email: ____________________________________

○ I Decline Electronic statements and request Paper statements

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.

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.

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

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

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

Requested Dates of Service:

All Dates of Service

2 years prior from the 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.

____

Printed Name of Patient or Representative

Relationship: _____________________

____

Signature of Patient or Patient's Representative

Other: ______________________

Approved 11/15/2024

MORGAN FAMILY MEDICINE

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.

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

MORGAN FAMILY MEDICINE

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? ___________________________

Employment: ☐ Currently Employed ☐ Retired ☐ Unemployed ☐ Student
Type of work: ___________________________
Relationship: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Other
Sexually Active: ☐ Yes ☐ No How many children do you have? ______________

Sexual Practices: ___________________________

Smoking Status: ☐ Never smoked ☐ Former Smoker ☐ Current every day ☐ Current some days
Cigarettes per day: __________ Quite Date: __________ Total Years Smoked: __________
Vape/E-cigarette: ☐ Never used ☐ Former User ☐ Current every day user
Carts/Refills per week: __________ Nicotine: ☐ No ☐ Yes __________mg
Smokeless Tobacco: ☐ Never Used ☐ Former User ☐ Current snuff user ☐ Current chew user
☐ Current moist powered tobacco user
Alcohol Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Type: ______________
History of or current use of illicit or recreational drugs? ☐ No ☐ Yes Type: ______________
Caffeine consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

MORGAN FAMILY MEDICINE

FAMILY HISTORY

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

Conditions	Father	Mother	Siblings	Maternal Grandparents	Maternal Aunt/Uncle	Paternal Grandparents	Paternal Aunt/Uncle
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							