Morgan Road Family Care

Bruce Silverstein, MD
Jaclyn Snyder, RPA-C
7445 Morgan Road / Liverpool NY 13090
315-420-5056

New Patient Intake Form

First Name:_____ Last Name:_____ DOB:___/____/_____

Street_____City_____ Zip Code_____

Legal Sex*:____ Home Phone:_____ Mobile Phone:_____
Preferred Phone: Home or Mobile (circle one)

Emergency Contact:_____ Relationship:_____
Emergency Contact Phone_____ Marital Status:_____
Occupation:_____ Employer:_____
Pharmacy:_____ Pharmacy Address_____
Mail-away Pharmacy_____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, cardiologist, etc.)
Doctor's Name:_____ Specialty:_____
Doctor's Name:_____ Specialty:_____
Doctor's Name:_____ Specialty:_____
Doctor's Name:_____ Specialty:_____
Doctor's Name:_____ Specialty:_____
Doctor's Name:_____ Specialty:_____

INSURANCE:
Primary Insurance Company:_____ ID#_____
Subscriber Name (Name on card):_____
Relation to Patient:_____
Subscriber Address: _____

Patient Financial Obligation Agreement: I understand that all applicable copayments are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I consent to have the Practice use and disclose my protected health information for payment, treatment, and health care operation purposes, and for such other purposes that are permitted under the HIPPA or other federal or state law without my written authorization.
Signature:_____Date:_____/_____/_____

*Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

GENERAL MEDICAL QUESTIONNAIRE

Have you **ever** had any of the following?

Asthma/Breathing Problems	Y N	Heart Disease/Disorder	Y N
Arthritis	Y N	Lung Disorder	Y N
Bleeding/Clotting Disorder	Y N	Liver Disease	Y N
Blood Pressure Disorder	Y N	Neurological Disorder/Chronic Headaches	Y N
Blood Transfusion	Y N	Psychiatric Disorder/Illness	Y N
Bowel/Stomach Problems	Y N	Pulmonary Embolism/DVT	Y N
Cancer	Y N	Stroke	Y N
Cholesterol Disorder	Y N	Seizure or Epilepsy	Y N
Diabetes	Y N	Thyroid Disorder	Y N
Eye Disorder (ie. Glaucoma, cataract)	Y N	Urinary/Kidney Disorder	Y N
Gynecological Issues (if relevant)	Y N		

Please list all past surgeries and hospitalizations and their approximate date(s)

Procedure/Hospitalization	Date	Complications

Please indicate all major conditions or illnesses that your immediate family members have or have had			
Relative	Condition(s)	Living	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Other:		Y N	

Do you currently smoke? Y N

If no, have you been a smoker before? Y N Years Smoked ___ Packs per day ____

Do you use other tobacco products? Y N Consume Alcohol? Y N If yes, drinks per week ___

If Relevant: Any past pregnancies? Y N

If yes, how many ___ How many deliveries ___

Do you have any allergies to medications or other substances (food, pets, etc.)? Y N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

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No Show, Late Cancellation Fee and MRFC Office Policy

When a patient misses an appointment without providing advance notice other patients are prevented from receiving care. We reserve the right to charge for these occurrences.

Due to high patient demand and appointment availability we have instituted a fee of **$50.00** for no show and late cancellations.

*If a **NEW PATIENT APPOINTMENT** is missed another appointment will not be offered until this fee is paid.

Therefore, kindly give **24 hour advance notice** to cancel/reschedule appointments to avoid this fee.

By signing below, I acknowledge that I have read and understand the No Show and Late Cancellation Fee policy.

_____ _____

Print Name Date of Birth

_____ _____

Patient Signature Date