Dear Patient:

Welcome to Morgan Road Family Care. We are an office within the FamilyCare Medical Group. We are honored that you have chosen us as your health care provider. FamilyCare Medical Group offers a wide variety of services from a state-of-the-art sleep center to co-located behavioral health services in several of our offices. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner, and we strive to provide our patients with same-day office visits with a member of their care team.

Please make sure that you bring your insurance card and a photo ID with you to each appointment. If you have any information changes or have seen any other doctors, please be sure to let our clinical staff know so that we can update your information. We require all new patients to be vaccinated against COVID-19. Please review the vaccination protocol at the end of our Medical Questionnaire included with this packet.

We ask that you allow plenty of time to arrive at the office for your appointment. Please plan on arriving at least 15 minutes prior to your first appointment.

To ensure that we provide you with quality care, we need certain information from you. Please fill out the forms located under the **Patient Forms** tab and bring them with you to your appointment. If you are unable to print out the forms call us at 315-420-5056 and we will mail them to you. All co-pays and past balances are due at the time of service, unless a prior agreement has been made with our billing department. If you need information about insurance coverage, please let us know and we will assist you.

If you have an urgent after hours matter, you can call our office at 315-420-5056 to be connected with our after hours answering service or visit an Urgent Care or Emergency Room facility.

We look forward to working with you as your health care provider and we would like to thank you again for choosing Morgan Road Family Care-FamilyCare Medical Group for all of your health care needs.

Sincerely,

Bruce N. Silverstein, MD

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

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

Medication Name	Dose		Medication Name	Dose

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 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 Do you currently Vape? 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 ___

COVID-19 VACCINATION Information: State of Administered in New York / Other. Bring Card to 1st appt.

_____MODERNA x2 plus booster ____ PFIZER x2 plus booster ____J&J x2 OR plus Moderna or Pfizer

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

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 for standard appointments. Our no show and late cancellation fee for Complete Physicals and other specialty appts is $75.00. The fee for missed New Patient Appointments is $100.00. Therefore, kindly give **24 hour advance notice** to cancel/reschedule appointments to avoid these fees and possible discharge from the practice.

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

______________________________ ______________
Print Patient Name **Date of Birth**

______________________________ ______________
SIGNATURE of Patient or Guardian Date

☐ I have read, understand and agree to the terms governing the Morgan Road FamilyCare Office policy.

IF YOU WISH TO RECEIVE EMAIL REMINDERS PLEASE **PRINT** EMAIL BELOW

____________________________________@____________________