

Morgan Family Practice, LLC
141 Golfview Drive, Arab, AL 35016
Phone: 256-459-7771 Fax: 256-673-2212

New Patient Information Pack

Date: _____

The attached patient information packet **MUST be ENTIRELY** completed including all medicines prescribed.

Dr. Morgan will only accept you as a new patient after your first visit to the office and your initial evaluation (including a review of your medical history) has been completed.

Name: _____ Age: _____

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Date: _____

SS#: _____ **Date of birth:** _____ **Sex:** Male or Female

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ **Alternate Phone:** _____

Employer: _____ **Phone:** _____

Race: _____ **Language:** _____ **Weight:** _____ **Height:** _____

Marital Status: S M W D **Spouse Name:** _____ **Phone:** _____

Person to contact in case of EMERGENCY (Outside your home): _____

Relationship: _____ **Phone:** _____

Insurance Information:

Primary Policy: _____

Contract Number: _____ **Group Number:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relation:** _____

Secondary Policy: _____

Contract Number: _____ **Group Number:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relation:** _____

Name: _____ **Date of Birth:** _____

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I consent to necessary treatment, including drugs, medicine, procedures and conduction of x-ray and other studies that may be used by Morgan Family Practice, LLC, or staff.

I authorize Morgan Family Practice, LLC, to furnish my medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to an on-the-job injury.

I hereby authorize payment directly to Morgan Family Practice, LLC, of benefit otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges of these services. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits. For services furnished by Morgan Family Practice, LLC, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts I hereby waive all claims of exemption under the State of Alabama and agree to pay if necessary all cost of collection, including attorney fees.

I have received a Notice of Privacy Practice. I release Morgan Family Practice, LLC, to release any medical information regarding myself to the people listed below.

Release Medical Information to the Following People:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature

Date

Please initial the option that applies to you regarding telephone messages:

_____ I do not authorize Morgan Family Practice to leave messages regarding my care.

_____ I authorize Morgan Family Practice to leave relevant medical information on my answering machine or voicemail. Primary Phone: _____ Secondary Phone: _____

Name: _____ Date of Birth: _____

Providers of your Medical Care

Current Primary Care Doctor: _____ Phone: _____

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Date of Last office visit: _____ Name/Location of Clinic: _____

Please list all specialty physicians, chiropractors, herbalist and therapists that you use

Physician Name:	Specialty:	Phone:

Medications

Please include prescriptions, over-the counter medications, vitamins, and supplements. *If you need additional space please use the back of this form.

Medication	Dose	Route	Frequency

Allergies: Please list all medication or food allergies and the reaction that you have to them.

Medication/Food	Reaction

Daily Aspirin Use:

Have you discussed taking a daily aspirin with your doctor? ____ Yes ____ No

Immunizations:

When was your last flu shot? _____ When was your last pneumonia vaccine? _____

Pharmacy Information:

Pharmacy: _____ Phone: _____

Address: _____

Mail Order: _____ Phone: _____ Fax: _____

Name: _____ **Date of Birth:** _____

Your History

Medical History: Please circle all that apply.

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Allergies	Heart Failure (CHF)	Heart Murmur	Seizures
Anemia	Clotting Disorder	HIV/AIDS	Sickle Cell Anemia
Anxiety	COPD	High Blood Pressure	Stroke
Arthritis	Depression	Kidney Disease	Substance Abuse
Asthma	Diabetes	Meningitis	Thyroid Disease
Blood Transfusion	Emphysema	Heart Attack	Tuberculosis
Cancer	Reflux, Heart Burn (GERD)	Nerve/Muscle Disease	Ulcers
Cataracts	Glaucoma	Osteoporosis	

Other Medical History:

Surgical History: Please list all surgeries and past hospitalizations. * If you need additional space please use the back of this form.

Date	Procedure —please specify left or right if surgery was performed on a joint or extremity	Surgeon/Location

Men Only:

Have you ever had a prostate exam? ____ Yes ____ No If yes what was the date? _____
Have you ever had a colonoscopy? ____ Yes ____ No If yes what was the date? _____

Women Only:

Date of your last menstrual cycle? _____ Regular? _____ Irregular? _____
Date of your last pap smear? _____ Date of your last mammogram? _____
Have you ever been pregnant? ____ Yes ____ No How many live births? _____ Miscarriages? _____
Have you ever had a colonoscopy? ____ Yes ____ No If yes what was the date? _____

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Social History:

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Do you use tobacco products? ____ Yes ____ No What type? _____ How often? _____

Do you drink alcohol? ____ Yes ____ No How often? _____ Do you use illegal drugs? ____ Yes ____ No

Do you exercise regularly? ____ Yes ____ No What type? _____ How often? _____

Do you have and Advanced Directive? ____ Yes ____ No, would you like information regarding Advanced Directives? ____ Yes ____ No

Family History: Please list your blood relatives' health problems.

Relative	Age	Deceased? Y/N	Heath Issues
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Office Policies:

-Payments: All copays are due at the time of service. Balances should be paid in a timely manner; if necessary, we can establish a payment plan. Additional services, such as weight loss injections & DOT physicals must be paid at the time of service.

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-Refills: Patients must call our office 2-3 business days prior to running out of a medication and request refills. Patients must remain compliant with appointments and lab work. Patients must pick up paper copies of controlled medication prescriptions from our office. No one other than the patient may pick up the prescriptions for controlled medication, unless the patient is underage and then it should only be the patients legal guardian.

-Scheduled appointments: Appointments that are scheduled prior to the day of the appointment.

-Work-in appointments: If you call and request a same day appointment, you will be considered a work in and will be seen in between scheduled appointments.

-Walk-in appointments: Walk-in appointments should be for emergencies only, all other patients should call prior to arriving to the clinic. Walk-in's will be accepted for established patients only, between the hours of 8-11am M-F and 1-4pm M-Th, when schedule availability is open. If there is not availability, patients may be asked to schedule an appointment at another time.

-Late for scheduled appointments: If you are unable to be on time for your scheduled appointment, please call our office and verify that you do not need to be rescheduled. If you arrive late, you will then be considered a walk-in appointment.

-Wait times: We are unable to guarantee wait times, as emergencies do arise. Our staff works hard to ensure that our office run as efficiently as possible, but patient care is our top priority.

-NO SHOWS: Defined as a scheduled appointment that the patient does not call and speak to someone in our office to cancel. After 5 NO SHOW appointments you will be charged a \$25.00 fee for each uncanceled appointment going forward.

-FMLA/Miscellaneous paperwork: \$75 office visit, that cannot be billed to insurance and must be paid upfront. Dr. Morgan must have been the treating physician, in order for us to be able to fill out the paperwork. We are only able to include dates that the patient was treated in our office.

-Prior Authorizations for Prescription Medications: Require an appointment.

-Transferring of medical records to another primary care physician (PCP): Once we have received a request for medical records from another PCP and records are sent, you will no longer be a patient of Morgan Family Practice and will not be accepted back into of practice.

I, _____ acknowledge that I have read and will comply with the policies of Morgan Family Practice. Non-compliance with the policies and result in dismissal from our practice. These policies are subject to change at the discretion of Dr. R. Keith Morgan.

Signature: _____ Date: _____