Morningstar Healing Arts

Please print your information in ink and clearly. Today's date: ________________

Patient's Legal Name:____

Preferred Name: ____ Legal Gender: M / F

Birth date: __________________ Social security # _________ - _______ - __________

Mailing Address: ____

City __________________________________ State____________ Zip _______________

Billing Name & Address (if different than above)**:** _________________________

____

Please circle your primary phone: Home:________________ Cell: _________________

Work:________________ext._______ Email: _____________________________________

Emergency contact: _______________________________ Phone: __________________

Relation to contact:____

In case you need a prescription at time of appointment:

Pharmacy:_________________________________**City/Zip**______________________

Primary insurance: _______________________________________ PCP Copay $_______

Secondary insurance: ____

If the Policyholder is different from above patient, please print additional information.

Policyholder name: ____________________________________ Birth date: ____________

Patient's Relation
To Policyholder:____

Authorization & Assignment of Benefits

1. I authorize medical treatment for ______________________________________ (patient's name)
2. I authorize Howard W. Morningstar, MD, Sue Morningstar, WHCNP, Aja Morningstar, MD and staff to collect and release medical or incidental information as necessary for medical care and for billing insurance on my behalf.
3. I authorize payment of my medical insurance benefits to Howard W. Morningstar, MD and Aja Morningstar, MD for medical services rendered by them or by their staff under their supervision.
4. ***I understand that I am financially responsible for any services provided that are not covered by my medical insurance***. Balances still due 90 days from the date of service will become my responsibility. We will assess a statement charge of $7 per month on past due balances. A $10 billing charge will be applied if we need to bill you for your co-pay.

Signed: ____**Date:** __________________
(If other than the patient, please state your relation to the patient, i.e. parent, guardian)

Morningstar Healing Arts
Patient Privacy Questionnaire & Instructions

We comply with all Federal and ethical standards to protect your privacy. We will only release information regarding your health care with your written consent and instructions as specified in the following questionnaire.

1. Can we call your **primary telephone number** to leave messages that mention ***only our practice name and the time of your appointment?*** (i.e. an appointment reminder call)

(circle) **YES** **NO**

*Is there an alternative number that we can leave the same type of msg?

(work, cell phone, other)____

2. Can we call your **primary telephone number** to leave messages that ***contain confidential information, such as x-ray and lab results or answers to your medical questions?***

(circle) **YES** **NO**

*Is there an alternative number that we can leave the same type of msg?

(work, cell phone, other)____

3. Please list any individuals with whom we may discuss your medical care:

Name: ______________________________________ Phone #: _________________________

Name: ______________________________________ Phone #: _________________________

Name: ______________________________________ Phone #: _________________________

4. I have received and will review the "HIPPA Notice of Privacy Practices"

Remember, when you filled out and signed your "Authorization & Assignment of Benefits", you also agreed to allow us to collect and release medical or incidental information as necessary for medical care and for billing insurance on your behalf.

These instructions will remain in effect until I ask that they be changed or cancelled.

Patient's Name:____

Signed: ____ **Date:** ______________________

(If other than the patient, please state your relation to the patient, i.e. parent, guardian)

Morningstar Healing Arts

Pediatric Intake Questionnaire: *Page 1 of 2*

CHILD'S PREFERRED NAME: ________________________________ Date of Birth:______________

CHILD'S LEGAL NAME:__________________________________ Today's Date: __________________

Pronouns______________________________ Gender assigned at birth_______________________

Person filling out this form: _____________________________ Relationship to child: ____________

Reason for today's visit: ____

Please list any other medical concerns regarding your child: ________________________________

____

____

Was your child adopted? __________

Where was your child born? ________________ Birth Weight________ Was there anything unusual about the pregnancy or delivery (infections? diabetes? medications? prematurity?)

____

Was your child breast-fed/chest-fed? _______ If so, for how long? ________________

Was your child born with any medical problems?____

Any chronic or repeated medical problems? ____

____

Any serious injuries or surgery? ____

Has your child ever been hospitalized? _____ When? ____

Reason for hospitalization(s):____

What vaccinations has your child received? DTaP, Polio, Hib, PCV13, MMR, HepB, HepA, Meningitis, Tetanus, Varicella, Gardasil, COVID 19, other? ________________________________

Any serious reactions? (describe) ____

Please list all medicines your child takes, either every day or often, including prescriptions, over-the-counter remedies, herbs, supplements, and vitamins: ______________________________

____

MEDICATION ALLERGIES: ____

List other health care providers your child has seen recently, what they were seen for, and any treatments used: ____

____

Please list any other concerns or comments you have regarding your child's development, history of abuse or other adverse experiences, diet, activity, behavior, or schoolwork:

____

____

____

Check here if your child is adopted _________

Do any close relatives have the following problems? (if known)

asthma	abnormal bleeding	smoking	heart disease
allergies	drug/alcohol dependency	cancer (kind?)	mental illness
HIV	inherited problems (kind?)	emphysema	seizures

Please give details for any of the above (which relative, kind of cancer, etc)

____

____

____

Other serious problems? If yes, please give details ____________________________________

____

What is parent's usual occupation? ______________________________ working now? __________

Are parents? (circle) Single Married Living with partner Separated Divorced Widowed

Household Members: Who lives in your home (continue on a separate sheet if needed)?

Name	Age	Relationship to child	Any medical or emotional problems?

Do you feel safe at home now? ____

Do you feel your child is safe at home now? ____

If you ever feel unsafe at home, this is a SAFE space to talk about it.

If any parent does not live with the child, where do they live? ______________________________

Who helps care for your child on a regular day?____

What is your support system for if parent or child are sick? _________________________________

Have there been any unusual life changes in your family in the last year?_____________________

____

How does family deal with life stresses? ____

Any smokers at home? ________ Any guns at home?_____ How are they stored?_______________

Are seat belts/car seats always used? ________ Bicycle helmets? __________

Describe a *typical day's diet* for your child:

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

How did you hear of our medical practice? ____

Is there anything you wish to add? ____