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)

CHILD'S NAME:_____ Date of Birth:_____ Date: _____

Your name: _____ Relationship to child: _____

Why did you bring your child to the doctor today? _____

Please list any other medical concerns regarding your child: _____

_____

_____

Where was your child born? _____ Birth Weight_____ Vaginal/Cesarean_____

Was there anything unusual about the pregnancy or delivery (reason for Cesarean delivery, infections, jaundice, NICU, diabetes, medications, prematurity, adoption)

_____

Was your child breast-fed? _____ If so, for how long? _____

Does your child have any congenital abnormalities or inherited problems?

_____

_____

Any chronic or repeated medical problems? _____

_____

Any serious injuries or surgery? _____

Has your child ever been hospitalized? _____ When? _____ what for?

_____

What vaccinations has your child received?: DTaP Polio HIB MMR HepB Tetanus Gardasil?

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 were they seen for? _____

What treatments were used? (diet, behavioral, bodywork, surgery, medications or…)

_____

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:

_____

_____

_____

_____

Do any close relatives have the following problems? (circle)

asthma	abnormal bleeding	smoking	heart disease
allergies	drug/alcohol dependency	cancer	mental illness
AIDS	inherited problems	emphysema	seizures

Other serious problems? If yes, please give details _____

_____

_____

What is your usual occupation? _____ Are you working now? _____

What is the highest grade you completed in school?_____

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

Do both parents live with the child? _____ If not, where does other parent live? _____

Household Members: Who lives in your home?

Name	Age	Relationship to child	Any medical or emotional problems?

Who helps care for your child if you are sick or at work?_____

Have there been any unusual stresses in your family in the last year? (serious illness or accident, death, moved, job loss, relationship changes) _____

_____

How do you deal with these or other life stresses? _____

Any smokers at home? _____ Any guns at home?_____ Are they locked?_____

Are seat belts 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? _____

_____

_____