# ***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: Aja*** *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? _____