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)

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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)

In order to be seen, these forms require completion.

*Please fill out **all five pages** of this confidential questionnaire as completely as you can. Feel free to ask our office staff for help if needed. If you're uncomfortable with any question, it's okay to leave it blank, or talk about it without writing it down. You're welcome to add whatever you feel will be helpful. By helping us know you as a whole person, you help us provide you with the best possible personalized health care.*

PREFERRED NAME: _____ Birth date_____ Today's Date_____

LEGAL NAME/GENDER (needed for insurance)_____

Pronouns_____ Gender assigned at birth_____

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

How did you hear of our medical practice? _____

Main reason for your visit: _____

Other health concerns: _____

_____

_____

_____

Other chronic health problems: _____

_____

Any religious restrictions on your medical care: _____

Medication allergies: _____

What other therapies are you using to improve your health or treat a medical condition?

_____

List any health care providers you have seen recently, what they were seen for, and treatments used:_____

_____

Please list dates for any of the following: complete physical_____pap/HPV screening_____

Bone density DEXA_____ Tetanus shot _____ Mammogram_____

Eye exam_____Colonscopy/Cologuard (circle)_____cholesterol labs_____

dental exam_____HIV test_____Prostate exam_____COVID vaccine_____

*Please **circle** any of the following that apply to you:*

Poor appetite	Nausea or Vomiting	Sinus problems	Slow healing
Lack of energy	Change in stools	Hoarseness	Frequent antibiotics
Trouble sleeping	Black stools	Mouth sores	Blood transfusion
Often sad	Bloody stools	Dentures	IV drug use
Alone in the world	Diarrhea	Nosebleeds	Trouble walking
Often anxious	Constipation	Chronic cough	Joint pains
Panic attacks	Abdominal pain	Frequent colds	Swollen joints
Trouble concentrating	Gallstones	Neck swelling	Backaches
Frequently angry	Jaundice	Always sweaty	Sore muscles
Violent behavior	Hemorrhoids	Short of breath;	Foot pains
Self-destructive	Often dizzy	by day? at night?	Breast lump
Frequent injuries	Fainting spells	Sleep in a chair	Nipple discharge
Physical abuse	Frequent headache	Snoring	Decreased libido
Emotional abuse	Weakness	Wheezing	Sexual difficulty
Sexual abuse	Numbness	Coughing blood	
Hopeless	Tingling	Painful breathing	Painful testicles
Considered suicide	Poor coordination	Chest pain	Testicle lump
Weight change	Clumsiness	Ankle swelling	Penile discharge
Chronic pain	Tremor	Racing heart	Enlarged prostate
Chronic sores	Seizures	Heart murmur	Slow urine stream
Hair loss	Blurred vision	Uneven pulse	
Fragile nails	Vision loss	Poor circulation	Irregular periods
Rashes	Glaucoma	Often feel cold	Painful menses
Acne	Itchy eyes	Often thirsty	Vaginal discharge
Changed mole	Eye pain	Frequent urination	Yeast infections
Lumps or swelling	Contact lenses	Urgent urination	Pelvic pain
Itching or hives	Hearing loss	Painful urination	Hot flashes
Heartburn	Ringing in ears	Flank pain	Unexpected vaginal bleeding (even one spot, if after-menopause)
Bloating	Ear infections	Bloody urine	
Gas or belching	Earaches	Urine infections	
Trouble swallowing	Ear discharge	Night sweats	
Food intolerance	Hay fever	Easy bruising	

Any other symptoms? _____

_____

Have you ever had any of the following? (circle)

Abnormal PAP	Eating disorder	Irritable bowel	Rheumatic fever
Alcoholism	Ear problems	Kidney disease	Seasonal allergies
Anemia	Eczema	Kidney stones	Seizures
Anxiety	Eye problems	Liver problems	Skin disease
Arthritis	Gallbladder disease	Lung disease	Stroke
Asthma	Gout	Mental illness	Suicide attempt
Bleeding problems	Fibromyalgia	Menstrual problems	Thyroid problems
Bone disease	Food allergies	Migraine	Tuberculosis
Broken bones	Frequent headaches	Neurologic problems	Ulcers
Cancer	Frequent infections	Obesity	Vascular disease
Chronic pain	Heart trouble	Osteoporosis	*Others (list):*
Depression	Hepatitis	Pancreatitis	_____
Diabetes	High blood pressure	Phlebitis	
Digestive problems	High cholesterol	Pneumonia	_____
Drug abuse	HIV	Prostate disease	

Please give details: _____

_____

_____

_____

Have you ever been hospitalized or had surgery?

	When?	Reason for hospitalization or surgery
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

Family History

Check here if you are adopted: _____ Do any blood relatives have the following? (circle)

Asthma	Abnormal bleeding	High cholesterol	Heart disease
Allergies	Drug/alcohol dependency	Cancer (kind)	Mental illness (kind)
AIDS	Inherited problems (kind)	Emphysema	High blood pressure
Stroke	Chronic infections	Diabetes	Osteoporosis

Other? _____

Please give details, such as which relative and type of disease if relevant _____

_____

Social History

Do you have any children? _____ Please list the years of their births: _____

How many sexual partners in the last year? _____ What genders were they _____

Have you ever had a sexually transmitted disease? (list) _____

Do you always practice "safe sex"? _____

What does "safe sex" mean to you? _____

Contraception? _____

Have you ever been sexually or physically assaulted or abused? _____

Do you feel safe at home now? _____

If you ever feel unsafe in your relationship, this is a SAFE space to talk about it.

Relationship status: _____ Who lives with you at home? (list below)

Name	Age	Relationship to you	Any medical problems?

Have you experienced any major stresses or life changes in the last year?

_____

How do you deal with stress?

_____

_____

_____

_____

How do others at home deal with stress? _____

Who helps you deal with life's problems? _____

What do you do to relax or have fun? _____

List concerns regarding your physical appearance or habits you wish to change: _____

_____

How many alcoholic drinks do you have daily? _____ weekly? _____
Have you ever felt you needed to cut down on your drinking? _____
Has anyone ever annoyed you by criticizing your drinking? _____
Have you ever felt guilty about drinking? _____
Do you feel you need a drink first thing in the morning? _____
Do you use tobacco now? (circle): cigarettes cigars e-cig pipe snuff chew
How many times a day do you use tobacco? _____ For how many years? _____
Have you ever used tobacco regularly in the past? _____ When did you quit? _____
Do you use any other drugs socially? _____
Have you ever felt you have overused any drugs? _____
Do you always wear a seat belt? _____ Do you ever drive while impaired? _____
Are there any unlocked guns in your home? _____
If you use a bicycle, do you always wear a bike helmet? _____
Do you have a POLST, living will or advanced directive? _____
Would you like to discuss your wishes regarding end of life care? _____

If you have a uterus: Date of last menstrual period: _____
Number of pregnancies and outcomes: _____
_____

Any complications with pregnancy? _____
_____

Everyone: Describe a *typical day's diet* (be honest!):
Breakfast: _____

Lunch: _____

Dinner: _____

Favorite snacks: _____

Glasses of water you drink daily: _____ Other daily drinks: _____

Is there anything you wish to add? _____

MEDICATION LIST

Please list ALL medicines that you take including prescription drugs, over the counter remedies, herbs, supplements and vitamins

MEDICATION NAME	DOSAGE	FREQENCY