



Dear Patient:

Welcome to Morgan Road Family Care. We are an office within the FamilyCare Medical Group. We are honored that you have chosen us as your health care provider. FamilyCare Medical Group offers a wide variety of services from a state-of-the-art sleep center to co-located behavioral health services in several of our offices. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner, and we strive to provide our patients with same-day office visits with a member of their care team.

Please make sure that you bring your insurance card and a photo ID with you to each appointment. If you have any information changes or have seen any other doctors, please be sure to let our clinical staff know so that we can update your information. We require all new patients to be vaccinated against COVID-19. Please review the vaccination protocol at the end of our Medical Questionnaire included with this packet.

We ask that you allow plenty of time to arrive at the office for your appointment. Please plan on arriving at least 15 minutes prior to your first appointment.

To ensure that we provide you with quality care, we need certain information from you. Please fill out the forms located under the **Patient Forms** tab and mail them to our office at Morgan Road FamilyCare 7445 Morgan Road, Liverpool, NY, 13090. If you are unable to print out the forms call us at 315-420-5056 and we will mail them to you. All co-pays and past balances are due at the time of service, unless a prior agreement has been made with our billing department. If you need information about insurance coverage, please let us know and we will assist you.

If you have an urgent after-hours matter, you can call our office at 315-420-5056 to be connected with our after hours answering service or visit an Urgent Care or Emergency Room facility.

We look forward to working with you as your health care provider and we would like to thank you again for choosing Morgan Road Family Care-FamilyCare Medical Group for all of your health care needs.

Sincerely,

Bruce N. Silverstein, MD

Morgan Road Family Care
Bruce Silverstein, MD
Jaclyn Snyder, RPA-C
7445 Morgan Road / Liverpool NY 13090
315-420-5056

New Patient Intake Form

First Name: _____ Last Name: _____ DOB: ___/___/___

Street _____ City _____ Zip Code _____

Legal Sex*: ___ Home Phone: _____ Mobile Phone: _____
Preferred Phone: Home or Mobile (circle one)

Emergency Contact: _____ Relationship: _____
Emergency Contact Phone _____ Marital Status: _____
Occupation: _____ Employer: _____
Pharmacy: _____ Pharmacy Address _____
Mail-away Pharmacy _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, cardiologist, etc.)

Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____

INSURANCE:

Primary Insurance Company: _____ ID# _____
Subscriber Name (Name on card): _____ Date of Birth _____
Relation to Patient: _____
Subscriber Address: _____

Patient Financial Obligation Agreement: I understand that all applicable copayments are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I consent to have the Practice use and disclose my protected health information for payment, treatment, and health care operation purposes, and for such other purposes that are permitted under the HIPPA or other federal or state law without my written authorization.

Signature: _____ Date: ___/___/___

*Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

GENERAL MEDICAL QUESTIONNAIRE

Have you **ever** had any of the following?

- | | | | |
|---|---|---|---|
| Asthma/Breathing Problems/Lung Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N | Eye Disorder (ie. Glaucoma, cataract) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N | Gynecological Issues (if relevant) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bleeding/Clotting Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Disease/Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Pressure Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N | Neurological Disorder/Chronic Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bowel/Stomach Problems | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Disorder/Illness | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N | Pulmonary Embolism/DVT | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Covid | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cholesterol Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N | Seizure or Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Depression | <input type="checkbox"/> Y <input type="checkbox"/> N | Urinary/Kidney Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

Do you have any allergies to medications or other substances (food, pets, etc.)? Y N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Allergy	Reaction

Please list all past surgeries and hospitalizations and their approximate date(s)

Procedure/Hospitalization	Date	Complications

Please indicate all major conditions or illnesses that your immediate family members have or have had

Relative	Condition(s)	Living	If deceased, at what age?
Mother		<input type="checkbox"/> Y <input type="checkbox"/> N	
Father		<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	

Do you currently smoke? Y N Do you currently Vape? Y N

 If no, have you been a smoker before? Y N Years Smoked ____ Packs per day ____

Do you use other tobacco products? Y N Consume Alcohol? Y N If yes, drinks per week ____

If Relevant: Any past pregnancies? Y N

 If yes, how many ____ How many deliveries ____

COVID-19 VACCINATION Information: State of Administered in New York / Other. Bring Card to 1st appt.
 ____ MODERNA x2 plus booster ____ PFIZER x2 plus booster ____ J&J x2 OR plus Moderna or Pfizer

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7445 Morgan Road,
Liverpool, NY 13090
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No Show, Late Cancellation Fee and MRFC Office Policy

When a patient misses an appointment without providing advance notice other patients are prevented from receiving care. We reserve the right to charge for these occurrences.

Due to high patient demand and appointment availability we have instituted a fee of \$50.00 for no show and late cancellations for standard appointments. Our no show and late cancellation fee for Complete Physicals and other specialty appts is \$100.00. The fee for missed New Patient Appointments is \$100.00. Therefore, kindly give **24 hour advance notice** to cancel/reschedule appointments to avoid these fees and possible discharge from the practice.

By signing below, I acknowledge that I have read and understand the No Show and Late Cancellation Fee policy.

Print Patient Name

Date of Birth

SIGNATURE of Patient or Guardian

Date

I have read, understand and agree to the terms governing the Morgan Road FamilyCare Office policy.

IF YOU WISH TO RECEIVE EMAIL REMINDERS PLEASE **PRINT** EMAIL BELOW

@_____