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 Name & Phone:____________________________ Relationship:_________________
Pharmacy:_______________________ Pharmacy Address & Phone #_________________________________
Mail-away Pharmacy____

INSURANCE:
Primary Insurance Company:_______________________ ID#______________________________
Subscriber Name (Name on card):____________________Date of Birth______________________
Relation to Patient:____
Subscriber Address: ____
Secondary 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.

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, cardiologist, etc.)
Doctor's Name:____ Specialty:____________________
Doctor's Name:____ Specialty:____________________
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Doctor's Name:____ Specialty:____________________

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GENERAL MEDICAL QUESTIONNAIRE

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

Condition			Condition		
Asthma/Breathing Problems/Lung Disorder	Y	N	Eye Disorder (ie. Glaucoma, cataract)	Y	N
Arthritis	Y	N	Gynecological Issues (if relevant)	Y	N
Bleeding/Clotting Disorder	Y	N	Heart Disease/Disorder	Y	N
Blood Pressure Disorder	Y	N	Liver Disease	Y	N
Blood Transfusion	Y	N	Neurological Disorder/Chronic Headaches	Y	N
Bowel/Stomach Problems	Y	N	Psychiatric Disorder/Illness	Y	N
Cancer	Y	N	Pulmonary Embolism/DVT	Y	N
Covid	Y	N	Stroke	Y	N
Cholesterol Disorder	Y	N	Seizure or Epilepsy	Y	N
Diabetes	Y	N	Thyroid Disorder	Y	N
Depression	Y	N	Urinary/Kidney Disorder	Y	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		Y N	
Father		Y N	
Sibling		Y N	
Other:		Y 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 ___

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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

____________________________________@____________________