MORGAN FAMILY MEDICINE

1404 E. 9th Street • Edmond, Oklahoma 73034 • (405) 330-8819 • FAX (405) 340-0892

NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST	FIRST	MIDDLE INITIAL	SEX:	BIRTH DATE:	AGE

SOCIAL SECURITY NO.:	MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	SPOUSES NAME:	RACE:

PATIENT'S ADDRESS:	REFERRING PHYSICIAN:	ETHNICITY:

CITY:	STATE:	ZIP CODE:	Are You: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired	PREFERRED LANGUAGE:

HOME PHONE:	WORK PHONE:	CELL PHONE:
( )	( )	( )

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company _____

Name of the Person who carries the Insurance Policy _____ Relationship to Patient _____

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient _____

Not Applicable ☐ Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

EMPLOYMENT INFORMATION

Patient's Employer _____ Ph# _____

Insured Employer _____ Ph# _____

If the patient is a minor, please list both parents names and employer

Mother _____ Employer _____ Ph# _____

Father _____ Employer _____ Ph# _____

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU:

HOME PHONE:	RELATIONSHIP TO THE PATIENT:
( )	

THIRD PARTY BILLING

Is Your Injury Work Related?	☐ Yes	☐ No
Is This Injury Due To An Accident?	☐ Yes	☐ No
If Your Injury Is MVA Related Have You Obtained an Accident Report?	☐ Yes	☐ No

I Authorize the RELEASE of any MEDICAL INFORMATION if necessary to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I, acknowledge and agree that I have received a copy of the TPG Privacy Notice.

Signature _____ Date _____

Form 400

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Notice of Privacy Practices (Notice);

- The Notice tells me how Morgan Family Medicine PLLC (The Practice) will use protected health information for the purposes of treatment, payment for treatment, and health care operations
- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records by the Practice for the purposes detailed in the Practice's Notice or Privacy Practices.
-

Patient's Name (print)_____

Patient's Date of Birth _____

This form must be signed by either the patient or by the patient's personal representative.
If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient: _____

_____

_____

_____ _____
Signature of Patient or Patient's Personal Representative Date

Current Contact Information for Patient or Personal Representative signing this form

Name (print)_____

Address _____

Telephone Number _____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or representative but did not because:

_____ It was emergency treatment
_____ I could not communicate with the patient
_____ The patient refused to sign
_____ The patient was unable to sign because _____

Staff signature_____ Date_____

MORGAN FAMILY MEDICINE

Authorization to release information

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of Morgan Family Medicine regarding my health, care, treatments, appointments, prescriptions, etc. to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers;

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Other: _____

I authorize the following individuals to call the office on my behalf to verify the status or appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions or samples that I have requested:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____

Patient Signature Date

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Angela Morgan, MD has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____ _____

Signature of Patient

Signature or Parent or Guardian
(if applicable)

_____ _____

Print Name of Patient

Print Name of Parent or Guardian

_____

Date