J. BRANDON MORGAN, M.D.
GENERAL SURGERY

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Dear valued patient,

Thank you for choosing our office for your surgical needs. We look forward to seeing you and helping you feel your best!

In our efforts to reduce wait times, we ask that you show up at the time of your visit. If you are more than 40 mins early for your appt, others who are scheduled before you will be seen first.

If you are more than 30 mins late for an appointment (without notifying our office) you may be asked to reschedule.

If you are unable to keep your appointment, please notify our office at least 24-hours in advance.

Please fill out the paperwork **completely** in the comfort of your home with your records and medications readily available.

Please have the following available upon check-in, otherwise your appointment may be rescheduled.

*** Your completed paperwork**
*** A list of current medications and allergies**
*** Driver's License or Picture ID**
*** Insurance Card(s)**
*** Any co-pay, deductible, or amount not covered by insurance**
- **Payment options include**
  - **Cash(exact change only)**
  - **Debit/Credit card**
  - **Personal Check**

*** If you do not have insurance, $240.00 is due at the time of your appointment. All other fees will be billed to you.**

If you have any questions or need directions, please contact our office. We look forward to your visit.

Sincerely,
Office Staff

Patient Profile

First Name: ________________________Last Name: ________________________Middle: ________________Date of Birth: ________________________

☐ Male ☐ Female SS#: ______________________Transportation(circle one): Personal N/H : __________________ Family Bus Phone #:_______________________

Mailing Address: ____ City: ______________________________St: ___________Zip:______________

Phone: Home: ____________________________Cell: _____________________________Email Address: ____

Preferred Communications: □ Phone □ Text □ Email □ Portal Is it OK to leave a detailed message? □ Yes □ No

Pharmacy: ____City: ________________________State:________Phone: _______________Fax:__________

Primary Physician: __________________________Referring Physician: ________________________Cardiologist: _________________________

DIALYSIS PATIENTS ONLY: Please provide treatment information below. **Dialysis Days (Circle days): Monday Tuesday Wednesday Thursday Friday Saturday Sunday**
Dialysis Times:
Facility Name:

I authorize the office of J. Brandon Morgan,. M.D. to communicate any emergency regarding my healthcare, appointment and/or billing information to the following people:

Name: _________________________________Relationship to patient: ________________________Phone #:__________________________

Name: _________________________________Relationship to patient: ________________________Phone #:__________________________

Name: _________________________________Relationship to patient: ________________________Phone #:__________________________

Name: _________________________________Relationship to patient: ________________________Phone #:__________________________

Patient Financial Agreement

The following information is provided to all our patients, new and established, to inform patients of our office financial policies and of patient financial responsibility requirements.

- We will be happy to bill your insurance as a courtesy; however, all charges, regardless of insurance coverage are the patient's responsibility. We do expect payment for your portion at the time of service (co-pays, co-insurance, deductibles). We ask that if your insurance has not paid within 45 days that you follow up with them. Our office contracts with most insurance carriers.
- If you are seen for both a wellness/annual exam and an illness of separate problem is also addressed, proper coding will be used which may result in a charge for both services. Additionally, some medically indicated lab work may not be covered by all wellness policies. Your individual contract with your insurance carrier will determine how your insurance will pay. We make every effort to bill each visit with the proper diagnosis and procedure codes according to national coding guidelines. Please understand that we cannot make exceptions to our coding practices due to federal and state legal compliance concerns, and we are unable to bill for services other than those documented in your medical record.
- We routinely send our laboratory testing to third-party laboratory companies. The providers may or may not participate with your health plan. You may request that we refer your testing to another location. This request will need to be done with each visit.
- Paperwork (for example Family Medical Leave Act (FMLA) & Short-Term Disability applications) will be completed within 2 weeks of presentation.

I have read and understand the above information and agree to comply with these financial policies.

Print Name: ____________________________________Signature: _______________________________________Date: _________________

Name of Responsible Party if Patient Not able to Sign: ____Relationship:________________

Patient Authorization Form

Patient Name:____ **Date of Birth:** ____________ **Date:** ____________

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You may request a copy of the Notice of Privacy Practices from our staff. Please read each authorization carefully and indicate your approval by signing on the line provided.

- I authorize the release of all medical records maintained by J. Brandon Morgan, M.D. PLLC, which relates to services I have received from, or the results of tests ordered by J. Brandon Morgan, M.D. PLLC. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and/or third party liability claim.

- I am giving permission for J. Brandon Morgan, M.D. PLLC to obtain my prior films, scans, labs, and any records including demographic, pharmacy and medication history that may identify me and that relates to my past, present, and/or future physical or mental health or condition and related health care services . I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of J. Brandon Morgan, M.D. PLLC to obtain my prior films, labs, and/or other records, I am giving my permission to call and/or fax on my behalf in order to get needed medical records and films.

- I authorize direct payment of benefits from my insurance plan to J. Brandon Morgan, M.D. PLLC I understand that I am responsible for payment of professional fees charged by J. Brandon Morgan, M.D. PLLC, which are not covered or not properly reimbursed under the terms of my insurance plan. J. Brandon Morgan, M.D. PLLC will file your insurance. You, the patient, are responsible for any personal balance. Any account turned over to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court costs in collecting that balance.
- I will provide J. Brandon Morgan, M.D. PLLC with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or answering machine to convey information regarding my care. Contact via e-mail is authorized, if I provided my e-mail address to J. Brandon Morgan, M.D. PLLC.

- I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxes or e-mails are used.

Signature: _______________________________________ Date: _________________

I have been offered a copy of J. Brandon Morgan, M.D. PLLC Notice of Privacy Practices for my own records.

My signature will also service as a PHI document release should I request treatment or records be sent to other Doctors/ Facilities in the future or consent for data to be exchanged electronically between providers/hospitals.

Patient Name: ___________________________________ DOB: _______________
Patient Signature: _________________________________Date: _______________

Patient Family Member if Patient Not able to sign: ___________________________________Relationship:_______________
Document on File for approved Signature: ____Date: __________________
Employee Initials:________________Date: _____________________

PATIENT HISTORY SHEET

Patient Name: ______________________________ Date of Birth: ______________ Today's Date: ______________

PAST MEDICAL HISTORY

☐I deny any past medical history

☐Anemia ☐ A-Fib ☐Hernia ☐Nervous Disorder
☐Anesthesia Problems ☐Depression ☐Hiatal Hernia ☐Pulmonary Embolism
☐Arthritis ☐Diabetes Type 1 ☐HIV/AIDS ☐Seizures
☐Asthma ☐Diabetes Type 2 ☐Hypertension ☐Sleep Apnea
☐Bleeding Problems ☐GERD ☐Hyperthyroidism ☐Stomach Ulcer
☐Blood Transfusion ☐Head/Neck Injury ☐Hypothyroidism ☐Stroke
☐Angina ☐Migraines ☐Kidney Disease ☐Cancer:__________
☐Colon Polyps ☐Heart Attack ☐Kidney Stones ☐Other:___________
☐Cong Heart Failure ☐Heart Murmur ☐Liver Disease ☐Other:___________
☐COPD ☐Hepatitis ☐Lung Disease

PAST SURGICAL HISTORY

☐I deny any past surgeries

*Indicate the date the surgery was performed:

☐Abdominal Surgery__________________________
☐Appendix__________________________________
☐Hernia____________________________________
☐Hysterectomy______________________________
☐Gallbladder_______________________________
☐Tonsillectomy_____________________________
☐Cardiac Surgery__________________________
☐Back Surgery_____________________________
☐Other: __________________________________
☐Other: __________________________________
☐Other: __________________________________

SOCIAL HISTORY

Do you use any tobacco products? ☐Current ☐Former ☐Never

- If current, choose all that apply: ☐Cigarettes ☐Vape ☐Cigars ☐Chew/Dip
- How much, how often? __________packs _________ day ____________ years

Do you consume any alcohol? ☐Current ☐Former ☐Rarely ☐Never

- If current, choose all that apply: ☐Beer ☐Liquor ☐Wine
- How much, how often? __________drinks _________ day ____________ years

Do you use any recreational drugs? ☐Current ☐Former ☐Never

- If current, choose all that apply: ☐Marijuana ☐Cocaine ☐Meth ☐Heroine ☐Non-Rx drug use
- How much, how often? __________drinks _________ day ____________ years

FAMILY HISTORY

☐I deny any relevant family history

Does anyone in your immediate family have a history of the following? (Check all that apply):

Stroke	Diabetes	Heart Disease	High Blood Pressure	Cancer	Type
☐Father	☐Father	☐Father	☐Father	☐Father	____________
☐Mother	☐Mother	☐Mother	☐Mother	☐Mother	____________
☐Sister	☐Sister	☐Sister	☐Sister	☐Sister	____________
☐Brother	☐Brother	☐Brother	☐Brother	☐Brother	____________
☐Grandfather	☐Grandfather	☐Grandfather	☐Grandfather	☐Grandfather	____________
☐Grandmother	☐Grandmother	☐Grandmother	☐Grandmother	☐Grandmother	____________

PATIENT'S PERSONAL HISTORY

CHECK only the symptoms that YOU have had within the past 6 months:

Constitutional
☐Fever
☐Night sweats
☐Weight gain
☐Weight loss
☐Exercise intolerance
☐Chills
☐Malaise (fatigue)

Eyes
☐Dry eyes
☐Vision change
☐Irritation
☐Eye disease / Injury

ENMT
☐Difficulty hearing
☐Ear pain
☐Frequent nose bleeds
☐Nose problems
☐Sinus problems
☐Sore throat
☐Bleeding gums
☐Snoring
☐Dry mouth
☐Mouth ulcers
☐Oral abnormalities
☐Teeth problems
☐Ringing in ears
☐Sinusitis

Cardiovascular
☐Chest pain
☐Arm pain on exertion
☐Shortness of breath when walking
☐Shortness of breath when lying down
☐Palpitation
☐Heart murmur
☐Ankle swelling

Respiratory
☐Cough
☐Wheezing
☐Shortness of breath
☐Coughing up blood
☐Sleep apnea

Gastrointestinal
☐Abdominal pain
☐Nausea
☐Vomiting
☐Constipation
☐Appetite issues
☐Diarrhea
☐Vomiting blood
☐Dyspepsia (indigestion)
☐GERD (reflux)

Genitourinary
☐Incontinence
☐Difficulty urinating
☐Hematuria (blood in urine)
☐Increased frequency

Musculoskeletal
☐Muscle aches
☐Muscle weakness
☐Arthralgias (joint pain)
☐Back pain
☐Swelling in extremities
☐Neck pain
☐Difficulty walking
☐Muscle cramps
☐Osteoporosis
☐Fractures

Integumentary
☐Abnormal mole
☐Jaundice
☐Rash
☐Laceration
☐Non-healing area
☐Changes in hair/nails
☐Psoriasis
☐Changes in skin color
☐Breast lump

Neurological
☐Loss of consciousness
☐Weakness
☐Numbness
☐Seizures
☐Dizziness
☐Migraine
☐Headache
☐Tremor
☐Gait dysfunction
☐Paralysis

Psychiatric
☐Depression
☐Sleep disturbances
☐Do not feel safe in relationship
☐Alcohol abuse
☐Anxiety
☐Hallucinations
☐Suicidal thoughts
☐Mood swings
☐Memory loss
☐Agitation
☐Dementia
☐Delirium

Endocrine
☐Fatigue

Hematologic / Lymphatic
☐Swollen glands
☐Bruising
☐Excessive bleeding
☐Anemia
☐Phlebitis

Allergic / Immunologic
☐Runny nose
☐Sinus pressure
☐Itching
☐Hives
☐Frequent sneezing

For Medical Staff Only: Height: ______ Weight: ______ Blood Pressure:___/___ Pulse:______ Temp:______

Date: ______________________ Reviewed By: __________________________________

PATIENT MEDICATION AND ALLERGY INFORMATION

Patient Name: ______________________________ Date of Birth: _______________ Today's Date: _____________

Are you allergic to any medicine? ☐Yes ☐No If yes, what? ____

Pharmacy: ____________________________________City/State: _________________________ Phone: _______________

Did you receive a flu shot within the last year? ☐Yes ☐No If yes, approximately when and where? __________________

Medication	Dose	Frequency	Reason	Prescriber