MICHAEL MOORE, M.D., P.A.

PATIENT NAME:_____
LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PRIMARY PHONE CONTACT #:_____ Home Cell SECONDARY #: _____ Home Cell

DATE OF BIRTH:_____ SS#:_____ SEX: M F MARITAL STATUS: (Circle) S M D W

EMAIL ADDRESS: _____

EMPLOYER:_____ ADDR:_____ PH:_____

IF FULL-TIME STUDENT, INDICATE SCHOOL CURRENTLY ATTENDING:_____

REFERRING PHYSICIAN/FRIEND:_____

PHARMACY NAME & LOCATION_____ PHONE#:_____

IS REASON FOR VISIT RELATED TO AUTO/WORK ACCIDENT: YES____ NO____
IF YES, PLEASE ADVISE THE FRONT DESK

PRIMARY INSURANCE: _____ **EFFECTIVE DATE:** _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____

POLICY HOLDER DATE OF BIRTH (IF DIFFERENT FROM PATIENT):_____

RELATIONSHIP TO POLICY HOLDER (Please Circle): Self Spouse Child Other (Please Specify):_____

POLICY HOLDERS EMPLOYER:_____

POLICY HOLDERS EMPLOYER'S ADDRESS:_____

POLICY HOLDERS WORK PHONE:_____

SECONDARY INSURANCE:_____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____

POLICY HOLDER DATE OF BIRTH (IF DIFFERENT FROM PATIENT):_____

RELATIONSHIP TO POLICY HOLDER (Please Circle): Self Spouse Child Other (Please Specify:_____

PLEASE SIGN BOTH SECTIONS:
ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits directly to Michael Moore, MD, PA for services described. I understand that I am responsible to pay for services including reasonable attorney fees and cost of collection in the event of default.
SIGNATURE:_____ DATE:_____

RELEASE OF INFORMATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for claims. I permit a copy of this authorization to be used in place of the original.
SIGNATURE:_____ DATE:_____

MICHAEL G. MOORE, M.D., P.A.

Name _____ Age_____ Were you referred by a physician? Yes _____ No _____
Who requested our services? _____ Family Physician _____
Reason for seeking medical attention _____ Right Left Both
Date of injury or duration of symptoms _____ Are you right or left handed? _____
Have you had any diagnostic studies for this condition, ie. MRI, Bone Scan, X-ray, etc? Please List_____
Have you seen anyone else regarding this condition? YES NO If yes, list names and dates _____
Auto/Work Related? YES NO (If yes, please advise the front desk)

Have you ever been diagnosed with any of the following medical conditions?:

	YES	NO		YES	NO		YES	NO
Alcoholism	____	____	Epilepsy	____	____	Migraines	____	____
Anemia	____	____	Goiter	____	____	Nervous System Disorder	____	____
Asthma	____	____	Hepatitis	____	____	Osteoarthritis	____	____
Bleeding Tendencies	____	____	Heart Disease	____	____	Polio	____	____
Cancer	____	____	High Blood Pressure	____	____	Rheumatoid Arthritis	____	____
Colitis	____	____	Kidney Disease	____	____	Sickle Cell Disease	____	____
COPD	____	____	Lung Disease	____	____	Stomach Ulcers	____	____
Depression/Anxiety	____	____	Lupus	____	____	Stroke	____	____
Diabetes	____	____				Tuberculosis	____	____

Other Medical Conditions: _____
Are there any law suits pending on your orthopedic condition? _____
_____
Please list any orthopedic surgeries and dates:
_____
_____
_____
_____

Please list any other surgeries and dates:
_____
_____
_____
_____

Please list all current medications and dosages:
_____
_____
_____

_____
_____
_____

Are you allergic to?: (check if you are)
Adhesive Tape ____ Arthritis Medicine ____ Aspirin ____ Cephalosporin ____ Codeine ____ Dyes ____
Iodine ____ Latex ____ Morphine ____ Mycins ____ Penicillin ____ Sulfa ____ Tetanus____
Foods (please list) _____
Others: _____
Do you currently use tobacco?: Cigarettes ____ Pipe ____ Smokeless ____ Amount per day: ____ Quit when? ____
Do you drink alcohol?: Beer _____ Liquor _____ Wine _____ Amount per day: _____ or per week: _____
What is your current occupation?:

Has anyone in your family had?:
High Blood Pressure ____ Heart Disease ____ Cancer*____ Diabetes ____ Bleeding Problems ____ Lung Disease ____
*If yes, what type of cancer?

Have you recently had any of the following problems or symptoms?:

	YES	NO		YES	NO		YES	NO
Abdominal Pain	____	____	Diarrhea	____	____	Loss of Bladder Control	____	____
Are you Pregnant?	____	____	Difficulty Starting Urine	____	____	Loss of Bowel Control	____	____
Blood in Urine	____	____	Dizziness	____	____	Nausea or Vomiting	____	____
Bloody or Black Tarry Stools	____	____	Fainting Spells	____	____	Numbness/Tingling	____	____
Breathing Difficulties	____	____	Fever or Chills	____	____	Pain or Burning Urination	____	____
Chest Pains	____	____	Headaches/Migraines	____	____	Unexpected Weight Loss	____	____
Cough	____	____	Irregular Heart Beat	____	____	Vision Changes	____	____
Cough with Blood	____	____						

Patient's Signature _____ Physician's Signature _____ Date _____

Michael Moore, MD PA
171 Franklin Turnpike ~ Waldwick, NJ 07463

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

____ Home Telephone: _____
- ____ OK to leave message with detailed information
- ____ Leave message with call-back number only

____ Written Communication:
- ____ OK to mail to my home address
- ____ OK to mail to my work address
- ____ OK to fax to _____

____ Cell Phone: _____
- ____ OK to leave message with detailed information
- ____ Leave message with call-back number only

____ Email: _____
- ____ OK to email detailed information

____ Work Phone: _____
- ____ OK to leave message with detailed information
- ____ Leave message with call-back number only

____ Other: _____
_____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or contact them at our main number.

Print Name: _____
Signature: _____
Date: _____

IF APPLICABLE:
** I give my authorization to release medical information on my behalf to _____
Please specify relationship to patient: _____ (i.e. Spouse, Parent, Guardian)

Print Name: _____
Signature: _____
Date: _____