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

DATE:___________________________

PATIENT NAME:____

LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS:____

CITY:__________________________________STATE:_______________ZIP CODE:_____________________________

PRIMARY PHONE CONTACT #:______________________ Home Cell SECONDARY #: _________________ Home Cell

EMAIL ADDRESS: ____

DATE OF BIRTH:_________________SS#:_______________________

REASON FOR SEEKING MEDICAL ATTENTION: ____

DATE OF INJURY/DURATION OF SYMPTOMS: ____

HAVE YOU HAD ANY DIAGNOSTIC STUDIES DONE FOR THIS CONDITION., i.e. MRI, Bone Scan, Xray, etc? Please list:

____

ARE YOU RIGHT OR LEFT HANDED: R L

WHAT IS YOUR OCCUPATION?____

WERE YOU REFERRED BY A PHYSICIAN?: YES NO If yes, physician's name, address and phone:

____

IS THERE ANYONE ELSE WE MAY THANK FOR REFERRING YOU TO OUR OFFICE?____________________________

IS YOUR VISIT RELATED TO Auto/Work ACCIDENT? YES NO (If yes, please advise the front desk)

Are you the policy holder: YES NO If NO please complete information below:

PRIMARY INSURANCE: ____ **EFFECTIVE DATE:** ___________________

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):____

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

POLICY HOLDER RELATIONSHIP TO PATIENT: Self Spouse Child Other (Please Specify):_________________________

POLICY HOLDER EMPLOYER NAME, ADDRESS AND PHONE:

____

____

Are you the policy holder: YES NO If NO please complete information below:

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:_____________________

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

Name ________________________________ Age________ HT:__________WT:____________ SEX: M F

Do you use tobacco (Cigarettes, Cigar, E-Cigs, Chew)? YES NO Marital Status: S M W D

Do you drink alcohol? YES NO If YES - please circle: Beer Liquor Wine AMT/Day________ Week________

Has a blood relative had any of the following? (Please Circle)

High Blood Pressure Heart Disease Cancer Diabetes Bleeding Problems Lung Disease

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

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

Other Medical Conditions: ____

FOR AGE 65 & OVER:
How many times have you fallen in the past year? _______ Were you injured as a result of the fall(s)? YES NO

FOR WOMEN ONLY - Any chance of pregnancy: YES NO

Please list any **NON –ORTHOPEDIC** surgeries and dates:
____
____
____

Please list any **ORTHOPEDIC** surgeries and dates:
____
____
____

Name of Primary Care Physician:____

PHARMACY NAME & LOCATION:_________________________________

Please circle any allergies: No Known Drug Allergies _____

Adhesive tape Amoxicillin Aspirin Codeine Dyes Erythromycin Iodine Latex Morphine
Penicillin Sulfa Tetanus Other: ____

Please list all current medications, dosages and reason for taking:
____ ____
____ ____
____ ____

Patient's Signature ______________________________ Date ______________________

Michael G. Moore, MD PA

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA 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 communications 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):

_____**Email**:______________________________

_____OK to email detailed information

_____**Written Communication**:

_____ OK to mail to my home address

_____ OK to mail to my work address

_____ OK to fax to:________________

_____**Phone**:______________________________

_____OK to leave message a detailed message

_____Leave message with call-back number only

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 HIPPA Compliance Officer in person or contact them at our main number.

Print Name:____________________________**Signature**:________________________________**Date**:______

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: (Please check one);

______I give my authorization to release medical information on my behalf to___________________________

Please specify relationship to patient: ______________________ (spouse, parent, guardian, other)

______ I do not give authorization to release information to anyone but myself

Print Name:____________________________Signature:____________________________Date:_________

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:_________________________