

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#: _____ MARITAL STATUS: S M W D

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? _____

NAME OF PRIMARY CARE PHYSICIAN: _____

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: _____

POLICY HOLDER DATE OF BIRTH: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: 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: _____

POLICY HOLDER DATE OF BIRTH: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: Spouse Child Other (Please Specify): _____

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Name _____ Age _____ HT: _____ WT: _____ SEX: M F

Do you use tobacco (Cigarettes, Cigar, Vaping, 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)

Bleeding Problems Cancer Diabetes Heart Disease High Blood Pressure 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: _____

Have you had a flu shot since August? YES NO If NO, reason: _____

FOR WOMEN ONLY: Any chance of pregnancy: YES NO

FOR AGE 65 & OVER:

How many times have you fallen in the past year? _____ When? (Month & Date): _____

Were you injured as a result of the fall(s)? YES NO

Do you have an Advance Care Plan? YES NO

FOR WOMEN AGE 65-85:

Have you been diagnosed with Osteoporosis? YES NO If NO, have you ever had a bone density test? YES NO

Please list any **NON-ORTHOPEDIC** surgeries and dates:

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

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:** _____