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 any FAMILY members had any of the following? (Please Circle)

Bleeding Problems Cancer Diabetes Heart Disease High Blood Pressure Lung Disease

Have **YOU** 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 _____

THIS FORM MUST BE COMPLETED AND SIGNED

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 communications of PHI be made by alternative means as listed below:

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

_____**Email:**_____ _____**Written Communication:**

_____OK to email detailed information _____ OK to mail to my home address

_____**Phone:**_____

_____OK to leave message a detailed message

_____Leave message with call-back number only

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

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:**_____

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:**_____

Appointment Cancellation Policy

Please note, that once you have booked an appointment with us it means that we have reserved time in our schedule exclusively for you.

If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a $25.00 fee.

To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your scheduled appointment by calling 201-689-0110 or emailing us at mgmoffice@verizon.net.

I have read the above policy and agree to the conditions.

_____ _____

Signature Date