Patrick Moore MD Inc.

PLEASE PRINT CLEARLY

Whom can we thank for referring you to our practice:_____

Patient Name: _____ Gender: ____M ____F

Patient Status: ____ Single ____Married ____Widow ____Separated ____Divorced

Birthdate: _____ Social Security #: _____

Address:_____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Parent / Guardian (if minor):

_____

Emergency Contact: _____ Relationship: _____

Phone: _____

Primary Insurance: _____ ID/Subscriber #: _____

Employer: _____ Work Phone: _____

Insured's Name if not patient: _____ DOB: _____

Insured's Social Security #: _____

Secondary Insurance: _____ ID/ Subscriber: _____

Name of Pharmacy: _____ Phone: _____

I give the physicians and office staff of Patrick Moore MD Inc. permission to discuss my medical condition with the following family members/friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

******DUE TO GOVERNMENTAL REGULATION WE ARE NOW MANDATED TO COLLECT FOLLOWING DEMOGRAPHIC INFORMATION******

Name: _____ Date of Birth:_____

Email Address: _____

Preferred Language:_____

RACE- Please select (circle) one of the following:

- ❖ African American
- ❖ American Indian or Alaska Native
- ❖ Asian
- ❖ Caucasian
- ❖ Native Hawaiian or Other Pacific Islander
- ❖ Other Race
- ❖ Unspecified

ETHNICITY- Please select (circle) one of the following:

- ❖ Hispanic or Latino
- ❖ Not Hispanic or Latino
- ❖ Unspecified

Patrick Moore MD Inc.

Name:_____ DOB: _____

Reason for your visit today:_____

Medical History: Do you currently have or have had any of the following conditions? (Circle all that apply)

High Blood Pressure	Diabetes	High Cholesterol
Kidney Failure	Heart Disease	Liver Disease
Stroke	Lung Disease	Asthma
Bleeding Disorder	Clotting Disorder	Hepatitis-Type:_____
Immune Deficiency	Varicose Veins Aneurysms	
Stomach Ulcers	Cancer-Type:_____	
Other:		

_____

Surgery History: (List all surgeries you had)

Date: _____ Procedure Done:_____

Date: _____ Procedure Done:_____

Date: _____ Procedure Done:_____

Date: _____ Procedure Done:_____

Date: _____ Procedure Done:_____

(If you need more space, please write additional procedures on back of this form)

Social History:

Do you currently or had smoked tobacco? Y / N

If Yes, about how many years did you smoke? _____ How many packs?_____

How much alcohol do you drink per day or on average? _____

Have you ever used in the past or present illicit drugs? _____

What medical conditions are present in your parents / brother(s) / sister(s)? (Please answer even if family member is deceased)

_____

_____

Name: _____ DOB: _____

Review of Systems:

Do you currently have any of the following symptoms? (Circle all that apply)

General: Weight Loss/Changes Fever/Chills Fatigue Change in Appetite Appearance Any Disability

Skin: Rashes Itching Changes in Skin Color Varicose Veins

Eyes: Blurred Vision Double Vision Glaucoma

Heart: Chest Pain/Discomfort Heart Murmur Heart Problems Inability to Walk Up Flight of Stairs

Lung: Shortness of Breath Cough Asthma

GI: Nausea/Vomiting Abdominal Pain Changes in Bowel Habits Blood in Stool Indigestion Reflux Swallowing Difficulty Constipation

Musculoskeletal: Joint Pain/Swelling Numbness/Tingling Sensation Back Pain/Injuries

Urology: Weak Urine Stream Frequent Urination Kidney Stones

Neurologic: Seizures/Convulsions Numbness Headaches Paralysis/Tremors Head Injury

Hematologic: Easy Bruising/Bleeding Blood Clots Anemia Slow Heal After Cuts

Please List All Medications You're Currently Taking (If you're an established patient list any **NEW** medications since your last office visit) If there are no changes to your medications write **NO CHANGE**:

Name of Medication	Dose	How Many Times/Day?

ALLERGIES TO ANY MEDICATIONS? _____

_____

_____

I understand that the above information is required to provide me with proper medical care in a safe and efficient manner. I have completed the questions to the best of my knowledge. Should further information be needed, I give consent to ask the respective health care provider or agency to release any necessary information. I will notify the doctor of any changes in my health or medication list.

Patient/Guardian Signature: _____ Date: _____

(FOR MEDICAL STAFF ONLY)

HT: _____ **WT:** _____ **B/P:** _____ **P:** _____ **R:** _____

Patrick Moore MD Inc.

CONSENT TO TREATMENT

The undersigned consents to the patient's medical and/or surgical treatment. The undersigned acknowledges that services have been adequately explained and that all [1] questions have been answered.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she as agent or as patient, that in consideration of the services to be provided to the patient, he/she individually obligates himself/herself to pay the account of the patient.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign payment directly to Patrick Moore MD Inc., of the insurance benefits to which I may be entitled. Requested information may be released to the insurance carrier.

NOTICE TO MANAGED CARE PATIENTS

Managed care insurances generally require that a representative, often a Primary Care Physician, authorize medical and/or surgical treatment provided by a Specialist before the plan will accept financial responsibility. Your signature below indicates that you agree to be responsible for payments if you receive services that are not authorized as required by your plan.

MEDICARE PATIENTS

Medicare Authorization (for signature on file): I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to the party who accepts the assignment.

CANCELLATION FEES

Be aware if you must cancel your surgery, you must give a 7 day notice or else there WILL be a cancellation fee of $150.00. There will be exceptions if the patient is sick or other health related conditions apply.

Patient/Guardian Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____

Patrick Moore MD Inc.

Patient Partnership Plan

Dear Patient,
Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health" we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings.
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings. These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-Up Appointments and Reschedule Missed Appointments.
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests.
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office to schedule an appointment to get my lab and test results at that time. Furthermore, I understand I cannot get lab and test results over the phone.

Inform My Doctor if I decide Not To Follow His or Her Recommended Treatment Plan.
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs or tests, even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____

Patient/Guardian Signature **Date**

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____

Physician/Health Care Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic methods.

To: _____

Name

_____

Address

_____ _____ _____

City State Zip

The medical information/records will be used for the following purpose: _____

This authorization is:

[ ] Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)

[ ] Limited to the following: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV _____ (initial)

Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

DURATION This authorization shall be effective immediately and remain in effect until _____

Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of Patient *or Legal/Personal Representative* Relationship *if other than patient*

_____ _____

Patient's Name (PRINT) Date

_____ _____

Patient's Social Security Number Patient's Date of Birth

_____ _____

Witness Name Witness Signature