Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
How did you hear about us:
Marital Status:
Language:
Race:
Ethnicity:
Employer name and number:
Name of physician who sent you to us:
Physician who treats you for general illness:
Do you give permission for copies of your records to be sent to your family/requesting physicians? Yes/No
Do you give permission for copies of your records to be sent to any hospital or physician you may be sent to by this office? Yes/No
Was this an injury? Yes/No Auto/Work/Other Date of Injury:
Were x-rays taken?

Guarantor Information (to whom statements are sent)

Name:
Address:
,
Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:

Middle Name: Policy/Group No.:

Address:

City: State: Zip:

Date of Birth:, Sex (please circle): **M** or **F**

Employer Name:

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**
- **The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices of Moore Orthopedics & Sports Medicine, P.A.**

Signed_____ **Date:**_____

Medical Release Form for Protected Health Information

I, _____(date of birth)___/___/____), give Moore Orthopedics & Sports Medicine, P.A., permission to speak to the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from Moore Orthopedics & Sports Medicine, P.A. This consent is valid until such time as I provide Moore Orthopedics & Sports Medicine, P.A. written revocation of it.

Moore Orthopedics & Sports Medicine, P.A. may speak with:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Please Complete The Entire Form

Name: _____

DOB: _____/_____/_____ **HT:** _____ **Ft.** _____**In.** **Weight:** _____**lbs.**

Primary Care Physician: **Referring Physician:**

Local Pharmacy:_____

What are we treating you for today? **Right** **Left** **Bilateral**

Foot/Toes Ankle Knee Hip Shoulder Elbow

Wrist Hand Fingers Fracture Back Neck

How long has it been bothering you?

___**Hours** ___**Days** ___**Weeks** ___**Months** ___**Years**

Is this related to an injury? If yes, please describe what happened, where and when?

_____

_____

What eases your pain? _____

What makes your pain worse? _____

Medications you are currently taking or tried for this problem? _____

_____

Have you had any previous treatment or testing on the area we are treating you for today? This would include the following: surgery, injections, physical therapy, nerve studies, MRI, X-rays, etc. If yes please explain and list the name of the physician or facility that treated you.

_____

_____

Current Medications:	Reason for use:	Prescribing Physician:

Medication Allergies: Please include your reaction

Name of Medication	Type of Reaction

Please circle any of the following health problems?

Asthma Cancer: _____ Diabetes Heart Attack, when____ cardiologist _____

Anxiety COPD Fibromyalgia Heart Disease Kidney Disease

Blood Clot Depression Gout High Blood Pressure Sleep Apnea

Seizure, when _____ neurologist_____ Stroke/TIA, when _____ neurologist_____

Surgical History

Surgical Procedure:	Date of Procedure:	Surgeon:

Family History: This would include; parents, siblings or grandparents

Cancer	
Diabetes	
Heart Disease	
Bleeding Disorder	

Social History:

Alcohol Use: None Socially/Occasionally Moderate Heavy

Tobacco: None Previous, quit? _____ Current Smoker: _____ PPD