MORE MD
Patient Information

Date: _____

Patient Name: _____
(Last) (First) (Middle)
Mailing
Address: _____ City: _____ State: _____ Zip: _____

SS#_____ DOB: _____ Age: _____
Home Ph #:_____ Cell Ph#:_____ Work Ph#:_____

Race: White_____ Asian____ Africian-American___ American Indian____ Hispanic____ Other____ Refused____

E-Mail_____ May we contact you: Yes No
Marital Status: *Single* *Married* *Divorced* *Widow* *Male/Female*_____

Primary Care Physician: _____ Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Pharmacy:_____ Location:_____Phone:_____
Patient Employer:_____

Please complete if Patient is a Minor

Responsible Party: _____ Relation to Patient_____
Address: _____City:_____ State: _____ Zip: _____
SS# _____ Hm Ph #:_____ WK Ph#_____
Do we have permission to treat minor child in your absence? Yes_____ No_____ Signature: _____

INSURANCE INFORMATION

Is your injury work related?_____

PRIMARY Name of Relation to
Insurance:_____ Policy Holder: _____ DOB: _____Patient:_____
Ins. Ph: _____Policy Holder Employer:_____ Wk#:_____
Policy Holder SS#_____ Policy ID#:_____ GR#:_____
Address:_____ City:_____ State:_____ Zip:_____
Secondary Insurance
Insurance:_____ Policy Holder: _____DOB:_____ Rel. to Pt. _____
Ins. PH#:_____ Policy Holder Employer: _____ Wk#: _____
Policy Holder SS#_____ Policy ID # :_____ GR # _____
Address:_____ City:_____ State:_____ Zip:_____

ASSIGNMENT AND RELEASE:

I hereby agree to accept financial responsibility for all charges incurred in the course of my treatment. In the case of Medicare or other insurance that the physicians have executed an agreement with, I understand that I am responsible for paying any deductibles or co-payments required under the terms of my insurance plan**. A fee of $25.00 for cancelled or no show appointments for less than a 24 hour notice.** Should collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney's fees. I hereby authorize the physicians at More MD to bill Medicare and/or my health insurance plan. I hereby authorize the release of information acquired in the course of the examination and treatment, should it become necessary to secure payment of benefits. **LABS:** you may be required to come back for any and all lab results and may require an office visit and charge.

Signature of Patient or Responsible Party:_____ Date:_____

Name:_____ **DOB:** _____ **Date:** _____

DRUG ALLERGIES

_____

_____

_____

_____

_____

Pharmacy Name, Location, Phone #_____

_____

Primary Care Physician:

_____

HOSPITALIZATIONS

Date	Reason

SURGERIES

CURRENT MEDICATIONS & STRENGTHS

_____ ____

_____ ____

_____ ____

_____ ____

_____ ____

_____ ____

_____ ____

[ ] see attached list

FAMILY HISTORY	Any Diseases that run in the family?
Father	
Mother	
Spouse	
Son(s)	
Daughter(s)	
Siblings	
Pets	

SOCIAL INFORMATION

Alcohol use _____

Type of alcohol _____

How much daily? _____

How many years? _____

Tobacco use **Yes/No (circle one)**

How much daily? _____

How many years? _____

When did you stop? _____

EXPOSURES

(Have you been exposed to any of the following?)

Asbestos? **Yes/No**

Sandblasting? **Yes/No**

Toxic fumes? **Yes/No**

explain:_____

Past Medical History

[ ]Rheumatic Fever
[ ]Headaches
[ ]Congestive Heart Failure
[ ]Heart Palpitations
[ ]Irregular heart rate
[ ]Diabetes
[ ]Heart Murmur
[ ]Allergies/Hay Fever
[ ]Arthritis

[ ] Ulcer
[ ]High Cholesterol
[ ]Dizziness/Fainting
[ ] Stroke
[ ] TIA
[ ] Anemia
[ ] Chest pain
[ ] Angina
[ ] Blood clot in legs
[ ]Nervous Breakdown
[ ] High Blood Pressure

[ ] Bronchitis
[ ]Valley Fever
[ ]COPD
[ ]Emphysema
[ ]Pneumonia
[ ]Hemoptysis
[ ]T.B. Skin Test
[ ]Tuberculosis
[ ]Lung Cancer
[ ]Fluid in lungs
[ ] Shortness of breath

PERMISSION FORM TO RELEASE MEDICAL INFORMATION

I _ _____, hereby grant permission to:
(Patient Printed Name)

_____
(Name of friend, relative, spouse, attorney, etc. granting to release medical information to)

To receive (**mark YES or NO on the items you are granting permission to be released**)

_____ medical information on my behalf.

_____ pick up prescriptions on my behalf.

_____ verify appointments on my behalf.

_____receive copies of medical records on my behalf.

_____ I authorize permission to leave messages on my voice mail.

_____ I authorize permission to fax my medical information to my home.

I am providing my physician a copy of the following documentation to keep in my medical file, (**mark YES or NO if you have the following documentation**)

ADVANCED DIRECTIVES: _____
HEALTH POWER OF ATTORNEY: _____
LIVING WILL: _____

This form will remain in effect until I revoke permission with a written notification.

Signature of Patient: _____ Effective Date: ____/____/_____

Printed Name of Patient:_____

Patient Name: _____ DOB:____/____/_____

Pharmacy: _____ Phone:_____

Address :_____

Medication	**Strength**	**Dosage**	**Frequency**
Example: Cipro	*250 mg*	*1 tablet*	*2 X day*

HIPAA Acknowledgment and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1966, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

– Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

– Obtain payment from designated third party payers

– Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been Informed by you or your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. It is available in your office in print form or on the office website www.moremd.net. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time except to the extent that the organization has taken action relying on this consent.

_____ ____/___/_____

Print Patient Name Date of Birth

_____ _____

Patient/Legal Representative Signature Legal Representative Relationship to Patient

MORE MD