MORE MD

New Patient Packet

Name : _____ ____/____/____
Last First Middle Initial Date of Birth

Home Address : _____
City ST Zip

Permanent Address : _____
City ST Zip

Home Phone: __ _____ Cell: __ _____ Work: _____

SS# : _____ Male/Female: _____ Marital Status : S M D W

Pharmacy Name: _____ Address/Cross Street:_____

Email: _____

Who was your Primary Care Doctor?: _____ Phone: _____

In an emergency please notify: _____ Phone: _____

What is the insured's name that carries your primary insurance? _____
If someone other than yourself,
what is their date of birth?_____ What is their SS#? _____

What is the insured's name that carries your secondary insurance?_____
If someone other than yourself,
what is their date of birth?_____ What is their SS#?_____

IS YOUR INJURY WORK RELATED? YES NO
Name of person who can authorize treatment: _____
Insurance Carrier:_____ Phone: _____

INSURANCE RELEASE

I authorize and request that payment under my insurance program be made directly to MORE MD for any services furnished for me. I also authorize the provider to release any medical information needed for payment of claims.

Signature: _____ 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

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