MOORE ORTHOPAEDICS, P.A.

1508 MEDICAL CENTER DRIVE
WILMINGTON, NC 28401

Account # _____

Today's Date _____

PATIENT REGISTRATION

(PLEASE PRINT)

PATIENT'S NAME last	first	middle				
LOCAL MAILING ADDRESS	CITY AND STATE	ZIP	BEST HOME OR CELL PHONE #			
SS #	MARITAL STATUS S M W D SEP	SEX M F	BIRTHDATE / /	AGE		
PATIENT'S EMPLOYER	HOW LONG EMPLOYED?	EMPLOYED: FULL-TIME ☐ PART-TIME ☐				
EMPLOYER'S ADDRESS	CITY AND STATE	ZIP	WORK PHONE # EXT #			
OCCUPATION	ARE YOU A STUDENT? YES ☐ NO ☐	IF STUDENT, WHERE?				
SPOUSE OR PARENT'S NAME	SS #	BIRTHDATE / /	SEX M F			
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION	BUS. PHONE # EXT #				
EMPLOYER'S ADDRESS	CITY AND STATE	ZIP				
IN CASE OF EMERGENCY, CONTACT	RELATION	PHONE #				
PERSON RESPONSIBLE FOR PAYMENT IF NOT ABOVE	STREET ADDRESS, CITY, STATE	ZIP	HOME PHONE #			
PRIMARY INSURANCE						
SECONDARY INSURANCE						

REASON FOR VISIT:	HOW LONG HAVE YOU BEEN HAVING PROBLEMS?	
IF ACCIDENT, HOW WERE YOU INJURED?	WORK RELATED? YES NO	DATE OF INJURY / /
WERE X-RAYS TAKEN? YES ☐ NO ☐	IF YES, WHERE WERE X-RAYS TAKEN?	
REFERRING DR./SOURCE	YOUR PHARMACY/ADDRESS	

MEDICAL HISTORY

1. LIST DOCTORS CURRENTLY TREATING YOU: _____

2. LIST ALL MEDICATIONS YOU ARE TAKING, WITH DOSAGE: _____

3. ARE YOU ALLERGIC TO ANY DRUGS? YES ☐ NO ☐ IF SO, LIST:

(PLEASE CONTINUE ON REVERSE SIDE)

4. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:

a. High blood pressure, chest pain, or heart disorders? ..... YES ☐ NO ☐
b. Diseases of the blood vessels - arteries or veins? ..... YES ☐ NO ☐
c. Asthma, emphysema, or other lung disease? ..... YES ☐ NO ☐
d. Cancer, tumor, or leukemia? ..... YES ☐ NO ☐
e. Diabetes? ..... YES ☐ NO ☐
f. Ulcers or gastritis? ..... YES ☐ NO ☐
g. Acid Reflux? ..... YES ☐ NO ☐
h. Liver, intestinal, or gallbladder disorder? ..... YES ☐ NO ☐
i. Kidney, bladder, or urinary tract disorder? ..... YES ☐ NO ☐
j. Blood, gland, or skin disorder? ..... YES ☐ NO ☐
k. Eye, ear, nose, or throat disorder? ..... YES ☐ NO ☐
l. Neurologic disorder, stroke, or paralysis? ..... YES ☐ NO ☐
m. AIDS or HIV positive test results? ..... YES ☐ NO ☐
n. Drug or alcohol dependency? ..... YES ☐ NO ☐
o. Mental disorder? ..... YES ☐ NO ☐

5. LIST BELOW THE DETAILS PERTINENT TO ANY YES ANSWERS NOTED ABOVE:

6. LIST BELOW ALL OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD AT ANY TIME:

7. IF FEMALE, ARE YOU PREGNANT? YES ☐ NO ☐

CONSENT FOR TREATMENT

I HEREBY AUTHORIZE THE PERFORMANCE OF ANY MEDICAL OR SURGICAL TREATMENT, WHICH MAY BE ADVISED AND RECOMMENDED BY MY ATTENDING PHYSICIAN AT MOORE ORTHOPAEDICS, WILMINGTON, NORTH CAROLINA. FURTHERMORE, I REQUEST THE USE OF ANY FACILITIES AND SERVICES OF MOORE ORTHOPAEDICS WHICH MAY BE NECESSARY OR BENEFICIAL IN THE PERFORMANCE OF SAID TREATMENT.

AUTHORIZATIONS

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT TO THE ABOVE REFERRING PHYSICIAN AND TO ALL PHYSICIANS TREATING ME. I ALSO AUTHORIZE MOORE ORTHOPAEDICS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENT OR I REMAIN A PATIENT.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. I UNDERSTAND THAT EVEN THOUGH I MAY HAVE SOME INSURANCE COVERAGE, I AM RESPONSIBLE FOR ANY CO-PAYMENT AND/OR DEDUCTIBLE WHEN SERVICES ARE RENDERED.

DATE _____ (SIGNATURE) PATIENT OR PATIENT'S GUARDIAN X_____