HOSPITAL FOR SPECIAL SURGERY

WELCOME TO THE OFFICE OF DR. PETER J. MOLEY

PATIENT QUESTIONNAIRE: **DATE OF SERVICE:** __________

NAME: ____ **DOMINANT HAND:** RIGHT ☐ LEFT ☐ **GENDER:** MALE ☐ FEMALE ☐

DATE OF BIRTH: __________

REFERRED BY: DOCTOR: ______________________________________ PATIENT: ______________________________________

CHIEF COMPLAINT: ____

ONSET OF SYMPTOMS: ____

MECHANISM OF INJURY: ____

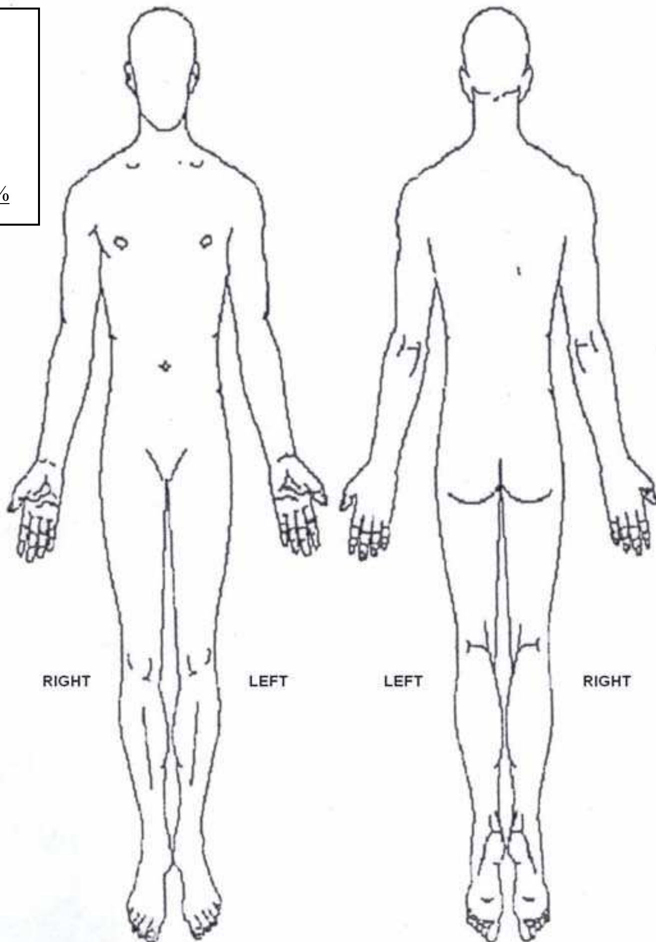
____

PLEASE COMPLETE THE FOLLOWING PAIN DRAWING AND RATING SCALE PRIOR TO YOUR VISIT

Please mark the drawing by using X's to indicate where you feel pain right now.

Neck: _____ %
Arm: _____ %
Back: _____ %
Hip: _____ %
Leg: _____ %

Total = 100 %



RATE YOUR PAIN

0 = no pain 10 = extreme pain

1. Right Now:	0	1	2	3	4	5	6	7	8	9	10
2. At Best:	0	1	2	3	4	5	6	7	8	9	10
3. At Worst:	0	1	2	3	4	5	6	7	8	9	10

(Please circle the corresponding number)

What makes the pain better?

____

____

____

What makes the pain worse?

____

____

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR THIS PROBLEM?

TESTS	NO	YES	DATE(S) OF YOUR TEST(S)
X-RAY	☐	☐	___
MRI	☐	☐	___
CT SCAN	☐	☐	___
MYELOGRAM	☐	☐	___
BONE SCAN	☐	☐	___

TREATMENTS	NO	YES	DATE(S) AND TYPE(S) ADMINISTERED
MEDICATIONS	☐	☐	___
INJECTIONS	☐	☐	___
SURGERY	☐	☐	___
PHYSICAL THERAPY	☐	☐	___

OTHER TESTS OR TREATMENTS: ___

PAST MEDICAL HISTORY:

LIST MEDICAL PROBLEMS: ___

LIST SURGERIES AND DATES: ___

LIST CURRENT MEDICATIONS: ___

DO YOU TAKE COUMADIN DAILY? ☐YES ☐NO

LIST ANY MEDICATION ALLERGIES & THE REACTION: ___

DO YOU HAVE ANY ALLERGY TO CONTRAST DYES? ☐YES ☐NO

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING PROBLEMS?

Heart Disease ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ Nerve Problem ☐ Osteoporosis ☐

Other: ___

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Weight Loss ☐ Fever/Chills ☐ Breathing Problems ☐ Heart Problems ☐ Bowel/Bladder Changes ☐

Numbness ☐ Weakness ☐ Night Pain ☐ Morning Stiffness ☐ Stomach Problems ☐

Other: ___

PLEASE PROVIDE YOUR SOCIAL HISTORY

Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐

EXERCISE: Never ☐ Occasionally ☐ Frequently ☐

SMOKING: Nonsmoker ☐ Smoker ☐ ___ packs per day

ALCOHOL CONSUMPTION: Never ☐ Occasionally ☐ Frequently ☐

Please take this opportunity to list some questions or topics you wish to discuss with the doctor during the consultation:

___

___

RESPONSIBILITY TO KNOW YOUR INSURANCE COMPANY

Within one insurance company there may be several programs with varying benefits and requirements. It is the patient's responsibility to know and keep up with their program and provisions.

- **Some Insurance Programs may require a specific facility to be used for having radiology, ultrasounds or blood testing.**
- **Some Insurance Programs "require" a Referral for each office visit and testing.**
- **Some Insurance Programs require Pre-authorization for various tests.**
- **Some Insurance Companies require "patients" to notify them of hospital admissions or trips to the emergency rooms.**

It is your responsibility to know and understand your own Insurance Program.
It is your responsibility to know the amount of your insurance deductible.
It is your responsibility whether this office is participating with your particular insurance plan and program.
It is your responsibility to know if you need a valid referral for today or future visits/tests.
It is your responsibility to advise this office of your programs requirements in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

These are not our regulations, they are your insurance companies' regulations and unless you follow them carefully, your insurance company may decline all or part of your claim. Your insurance carrier should have provided you with telephone numbers for you to use if you have any questions or concerns about your coverage.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. It is agreed and understood that should my insurance company reimburse me directly for medical or surgical services rendered by Dr. Peter Moley, which I have not made payments for, that the insurance payment received will be forwarded directly to Dr. Peter Moley, and that I am responsible for collection & attorney fees should my account be sent to collections, for failing to honor the above. I authorize the release of Dr. Peter Moley's records to referring & family physicians, and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

It is understood and agreed that my purpose in requesting examination and treatment is for medical purpose only and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation, except to provide a true and accurate copy of any medical records and x-rays in the possession and control of this office pursuant to an authorization by the undersigned.

I agree to allow Peter J. Moley's office to download my medication history from my pharmacy.
Patient Name: ____

Patient Signature: ____ Date: ____________

HOSPITAL FOR SPECIAL SURGERY

WELCOME TO THE OFFICE OF DR. PETER J. MOLEY

We are happy that you have chosen to see Dr. Moley today. Please fill out this paperwork to assist us in better serving you and your medical needs. We will be with you shortly.

PATIENT DATA:

NAME: ______________________________ DATE OF SERVICE: ______________

DATE OF BIRTH: ______________ SEX: __________ SOCIAL SECURITY NUMBER: ______________

ADDRESS: ______________________________ CITY: ______________ STATE: _____ ZIP: _________

HOME PHONE: ______________ WORK PHONE: ______________ FAX: ______________

E-MAIL ADDRESS: ______________________________ OCCUPATION: ______________________________

PERSON TO NOTIFY IN AN EMERGENCY: ______________________________ PHONE: ______________

INSURANCE QUESTIONNAIRE:

Please provide as much detail as possible regarding your insurance carrier's policies in the lines below. Thank you!

PRIMARY INSURANCE: ____

SUBSCRIBER'S NAME (who is the Primary Insurance Holder): ______________________________

SUBSCRIBER'S DATE OF BIRTH: ______________ SUBSCRIBER'S SOC. SEC. #: ______________

RELATIONSHIP TO PATIENT: ______________ SUBSCRIBER'S EMPLOYER: ______________

SUBSCRIBER'S ADDRESS: ____

POLICY NUMBER: ______________________________ GROUP NUMBER: ______________

PRIMARY PHYSICIAN: ______________________________ PHONE: ______________

REFERRING PHYSICIAN: ______________________________ PHONE: ______________

☐ I authorize the use of this form on all my insurance submissions.
☐ I authorize the release of information to my insurance company.
☐ I understand that I am ultimately responsible for my bill.
☐ I authorize payment to be made to the physician (in the rare event the physician receives payment for services by you and your carrier, adjustments will be made promptly).
☐ I permit a copy of this authorization to be used in the place of the original.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
If Patient is a minor, signature of guardian Date