



# 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: \_\_\_\_\_

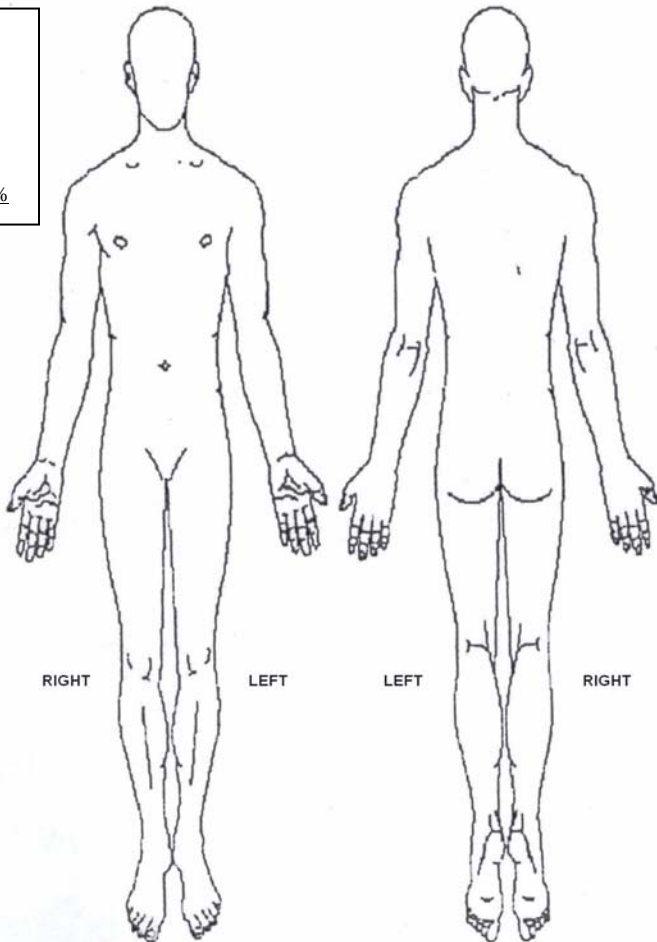
ONSET OF SYMPTOMS: \_\_\_\_\_

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?**

<u>TESTS</u>	<u>NO</u>	<u>YES</u>	<u>DATE(S) OF YOUR TEST(S)</u>
X-RAY	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT SCAN	<input type="checkbox"/>	<input type="checkbox"/>	_____
MYELOGRAM	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONE SCAN	<input type="checkbox"/>	<input type="checkbox"/>	_____

<u>TREATMENTS</u>	<u>NO</u>	<u>YES</u>	<u>DATE(S) AND TYPE(S) ADMINISTERED</u>
MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	_____
INJECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	_____
SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	_____
PHYSICAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

Over the past decade, the number of different health care programs has increased at an amazing rate. 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 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 ROOM**.

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 to know 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 program's requirements in advance, each and every time we provide 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 company's 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, the undersigned party, 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 payments 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 agreement. 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 purposes 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."

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## 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