## Dr. Gary Moskovitz - Spine & Orthopedic Center

**FOR OFFICE USE**

Date Account#

**TO BE COMPLETED BY THE PATIENT (PLEASE PRINT)**

| | | | |
|---|---|---|---|
| Name | Age | DOB | SSN# |
| Address | | | |
| City | State | Zip | |
| Phone# home ( ) | work ( ) | cell ( ) | |
| Email Address | | | |

**Employment Information:**
Occupation _____

Name of Employer _____

Address _____

**Emergency Contact:**
Name _____
Phone# _____
Relationship

**Financial Information (party responsible for payment)**

- ❑ Self ( same as above)

| | |
|---|---|
| ❑ Spouse<br>❑ Parent<br>❑ Child<br>❑ Other | Name |
| | Phone |
| | Address |
| | City<br>State Zip |
| | Age Date of Birth |
| | Employer<br>Employer Address Ph # at work |

## Health Insurance Information

| | |
|---|---|
| Insurance Company | |
| ID # | Group # |

****DO YOU HAVE MEDICARE? YES NO INITIAL_____**

**Patient Name** _____

**Please describe the condition you are being seen for.**

Is your condition the result of an injury? ___Yes __ No

If **'Yes'** Complete the **injury** section below.

**INJURY SECTION** **Date of Injury:** **Day** **Month** **Year** **State**

- ❑ Motor Vehicle Accident
- ❑ Worker's Comp injury
- ❑ Slip and Fall
- ❑ Home
- ❑ Other

Describe what happened.

Have you had any of the following treatments for your current condition/ injury.

- ❑ Physical Therapy
- ❑ Chiropractic Treatments
- ❑ Massage Therapy
- ❑ Medications
- ❑ Trigger point Steroid Injections
- ❑ Epidural Steroid Injections

List all **Medications** you are taking

**Allergies**

- ❑ Penicillin
- ❑ Latex
- ❑ Sulfa
- ❑ Codeine
- ❑ Lidocaine
- ❑ Aspirin
- ❑ Erythromycin
- ❑ Others:
- ❑ None

**Past Medical History**

Do you have or have you ever had:

- ❑ Angina/heart disease
- ❑ Heart attack
- ❑ Stroke
- ❑ High Blood pressure
- ❑ Lung Problems
- ❑ Asthma Emphysema-Bronchitis
- ❑ Pneumonia
- ❑ Bleeding Disorder

- ❑ Blood Clots
- ❑ Phlebitis
- ❑ Liver problems
- ❑ Jaundice/ Hepatitis
- ❑ Kidney Problems
- ❑ Stomach Problems
- ❑ Ulcers
- ❑ Thyroid Problems
- ❑ Cancer
- ❑ Diabetes
- ❑ Alcohol or Drug abuse
- ❑ HIV / AIDS

**Patient Name** _____

| Medical Conditions Under Current Treatment | **Anesthesia History**<br>❑ General Anesthesia<br>❑ Local<br>❑ Spinal<br>Describe any Adverse Reactions |
|---|---|
| **Past Surgical History**<br>List all operations you have had including dates | **Your Family Physician** |
| | **Who is your current treating physician?** |

| **Do You Experience** | **Social History** | **Family History** |
|---|---|---|
| ❑ Chest pain / shortness of breath<br>❑ Unexplained weight loss<br>❑ Loss of appetite<br>❑ Frequent night sweats, fevers or chills | Married Single<br>Divorced Widowed<br><br>Who else lives in your household?<br>Do you smoke? If Yes, how much.<br>Do you drink? If Yes, how much. | Please list any serious illnesses that run in your family.<br>Relative<br>❑ Cancer<br>❑ Heart Disease<br>❑ Stroke<br>❑ Diabetes<br>❑ Neurological/ Muscular disorder<br>❑ Other: _____ |
| Height _____ Weight _____ | | |

| **Do you have any metal in your body?** | **Are You Claustrophobic?** |
|---|---|
| ❑ Pacemaker<br>❑ Aneurysm Clips<br>❑ Heart Stents<br>❑ Other | ❑ YES<br>❑ NO |

Patient Signature _____

Date: _____