MELBOURNE HAND CENTER

2010 W. Eau Gallie Blvd, Suite 104 Melbourne, FL 32935

Ph: (321) 500 – HAND (4263)

Fax: (888) 782-9622

FULL NAME: ______________________________ **DATE OF BIRTH:** ____________

SOCIAL SECURITY NUMBER: ______________________

ADDRESS: ______________________________

____

____

HOME PHONE NUMBER: (____) ____________ **CELL PHONE NUMBER: (____)** ____________

PLEASE CIRCLE ONE: MALE/FEMALE EMAIL: ______________________________

EMERGENCY/HIPAA CONTACT PERSON: ______________________________

EMERGENCY/HIPAA CONTACT PHONE NUMBER: (____) ____________

I hereby give my permission to Dr. Kyle Moyles to administer treatment and to perform such procedures as may be deemed necessary. I hereby authorize my insurance benefits to be paid directly to Blackstone Hand Center, LLC and the release of any information required by third party payers in claim processing and understand that I am financially responsible for any remaining balance. Patient balances which remain unpaid after 90 days will accrue interest at 0.5% per month plus cost of collections. I also acknowledge that I have received the "Notice of Privacy Privacy Practices" for Blackstone Hand Center, LLC.

______________________________ (Signature) ______________________ (Date)

Kyle J. Moyles, M.D., M.B.A.
Orthopedic Hand Surgeon

Patient Intake Form

Name: ______________________ Date of Birth: __________ Primary Doctor: ______________

Occupation: ____________________ Working Status: ____________ Work Related Injury: Yes/No

Chief Complaint (Why are you here?): ____

Medications: ____

Pharmacy Name and Location: ____

Allergies with Reactions: ____

Review of Systems (Are you currently having or have you had problems with your):

	Circle		Describe Your Answer
Heart, Stroke, High Blood Pressure	No	Yes	____________________
Lungs, Breathing, Asthma	No	Yes	____________________
Diabetes, Thyroid Disorder	No	Yes	____________________
Bleeding Problems	No	Yes	____________________
HIV/AIDS	No	Yes	____________________
Cancer	No	Yes	____________________
Skin	No	Yes	____________________
Digestion, Ulcer, Acid Reflux	No	Yes	____________________
Arthritis, Gout	No	Yes	____________________

OTHER PROBLEMS? ____

Past Surgery (Year and Type): ____

____

Height: ________ Weight: ________ Do you smoke?: Yes / No Packs per day: _______ # of years: _______

Any Family Illness (Heart Attack, Cancer, Rheumatoid Arthritis, etc)?: ______________________

____

Who referred you to us?: ______________________________

Patient Signature: ______________________________ Date: ______________

Reviewed By: ______________________________ Date: ______________